MANA TANGATA WHENUA:

National Guidelines for Sexual and Reproductive Health Promotion with Māori

First Edition

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Contents

Contents 1

Acknowledgements 1

Background 2

Why the Guidelines? 2

The Guidelines 3

Pōhiri model 3

Characteristics of successful sexual and reproductive health promotion with Māori 5

Case Studies 5

1. Pōhiri element 6

Case studies: Pōhiri - Planning and relationship-building 8

2. Harirū element 11

Case studies: Harirū - Partnerships 12

3. Hākari element 14

Case studies: Hākari - Implementation 15

4. Poroporoaki element 18

Case studies: Poroporoaki - Evaluation and ongoing relationships 19

Conclusion 21

Development of the Guidelines 22

Kaupapa Māori approach 22

Methods 22

Consultation 22

Annotated review 23

Case studies 23

Health promotion 24

Māori and health in Aotearoa New Zealand 24

Māori and sexual and reproductive health 25

Socio-economic determinants and the Treaty of Waitangi 27

Māori and sexual and reproductive health promotion 28

Models for Māori sexual and reproductive health promotion 29

Te Whare Tapa Whā 29

Te Pae Mahutonga 29

Te Wheke 30

Kia Uruuru Mai a Hauora 30

Glossary 32

References 34

Acknowledgements

Toitū te kupu

Toitū te mana

Toitū te whenua

Whano, whano

Tū mai te toki

Haumi e! Hui e!

Tāiki e!

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Acknowledgements are also due to the organisations[1] that shared examples of best practice in sexual and reproductive health promotion with Māori.

1 New Zealand AIDS Foundation; Northland DHB; Auckland DHB; and Canterbury DHB.

Background

Why the Guidelines?

Mana Tangata Whenua: National Guidelines for Sexual and Reproductive Health Promotion with Māori (the Guidelines) was developed in response to requests from 'mainstream' and Māori sexual and reproductive health organisations for information to enable them to plan and deliver services that resonate for Māori communities. In particular, these organisations thought they could do a better job of working with Māori communities but were not sure how to achieve that outcome.

The Guidelines could have addressed a number of areas; however, as with all things Māori, the quality of the relationships that one has, as a member of a whānau, a hapū, and as a member of an organisation, is central to one's wellbeing in the world.[2] This being so, Te Whāriki Takapou made the decision to focus the Guidelines on building respectful, high quality relationships between sexual and reproductive health organisations and Māori communities. Good relationships are a value in and of themselves, and they are the platform from which to plan and implement sexual and reproductive health promotion activities that resonate for Māori.

The aim of the Guidelines is to assist sexual and reproductive health promoters (promoters) to undertake effective, Māori community-responsive health promotion as this is interpreted in its broadest sense. This could mean consulting with Māori, interpreting Māori health data, planning a health promotion website, or developing a pamphlet. The Guidelines will assist promoters to engage Māori communities and individuals in meaningful dialogue, which is the basis for effective sexual and reproductive health promotion with Māori. A series of online webinars to assist in the use of the Guidelines will also be available from April 2017. Please check the Te Whāriki Takapou website for details.

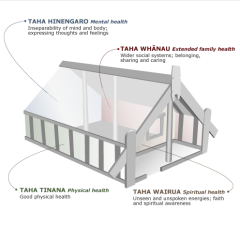
There is a body of literature that describes Māori models of health and the components of effective health promotion with Māori[3] but almost nothing about undertaking effective sexual and reproductive health promotion. Talking to promoters, the sense is that this is because they are focused on 'doing' sexual health promotion, with little time to document best practice. In order to develop the Guidelines, therefore, it was important to consult experienced promoters and ask them to reflect on what works, what doesn't work, and lessons learned.

2 Durie (2004); Mead (2003)

3 Ratima (2010)

The Guidelines

Any one of the more well-known Māori models of health – e.g., Whare Tapa Whā, Te Pae Mahutonga, Te Wheke, Kia Uruuru Mai a Hauora[4] – could be used to successfully operate a sexual and reproductive health promotion intervention. However, before embarking upon the intervention the first step is to bring health promoters and Māori communities together. The Guidelines authors chose to customise a less well-known Māori model of health, the Pōhiri model, to guide the process of relationship-building between health promoters and Māori communities. The decision was made to use the Pōhiri model because it is relatively easy to understand and follow. The fundamental principles of the pōhiri ritual upon which the model is based provide an ideal framework from which healthy relationship-building with Māori communities can proceed.



Pōhiri model

The Pōhiri model, developed by McClintock, Mellsop, Moeke-Maxwell and Merry,[5] is based on the traditional Māori pōhiri process of engagement, relationship building, and transformation.[6] The model incorporates traditional Māori cultural values, beliefs and protocols that, when correctly implemented, facilitate respectful and mana-enhancing relationships[7] between health promoters and Māori communities.

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4 Developed by Durie (1998, 1984); Durie (1999); Pere (1984); and Ratima (2001) respectively.

5 Note, the model developed by McClintock et al. (2010) uses the dialectal variation 'Pōwhiri'.

6 Mead (2003)

7 Boulton, Gifford, Kauika & Parata (2011)

At the heart of the Pōhiri model is the notion of respectful, positive engagement between two parties: tangata whenua, or 'hosts' (i.e., Māori communities) and manuhiri, or 'guests' (i.e., health promoters and organisations). The model highlights key elements that will assist promoters to work effectively with Māori - in particular, promoters with little experience of working with Māori communities and for whom the pōhiri process is unfamiliar.

Customising McClintock and colleagues' model for the Guidelines, four core elements of the traditional pōhiri process – Pōhiri, Harirū, Hākari and Poroporoaki – are aligned to four key stages of planning, partnering, implementing, and evaluating sexual and reproductive health promotion activities.

These four elements of the Pōhiri model, depicted in *Figure 1*, below, can be applied to most if not all sexual and reproductive health promotion involving Māori communities.

Figure 1: **The Pōhiri model as a framework for sexual and reproductive health promotion with Māori communities**

Characteristics of successful sexual and reproductive health promotion with Māori

In the four sections that follow, the characteristics of successful sexual and reproductive health promotion with Māori, drawn from selected literature, are elaborated in relation to each of the four elements of the Pōhiri model. The elements are:

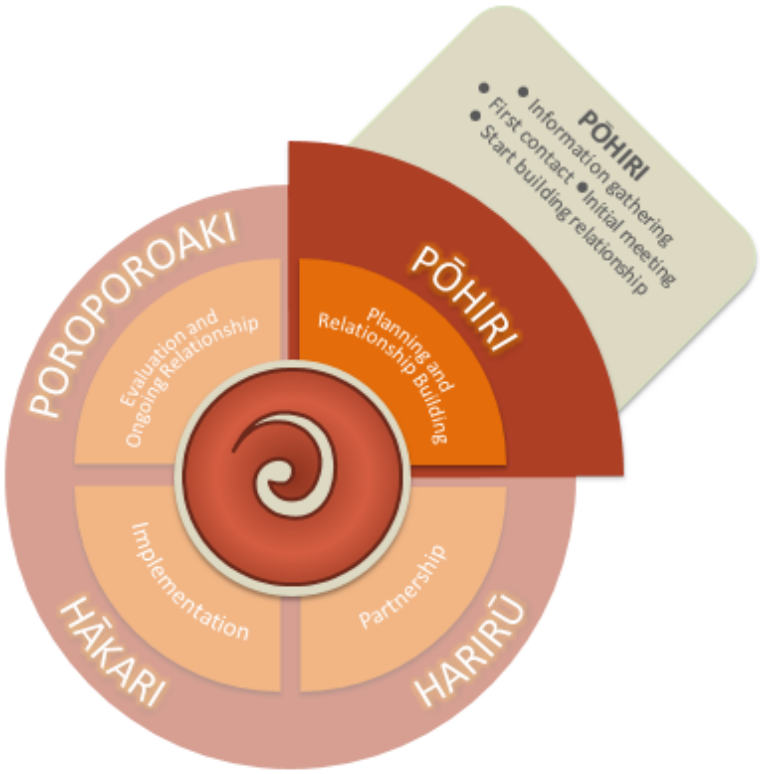
1. Pōhiri - Planning and relationship-building;
2. Harirū - Partnership;
3. Hākari - Implementation; and
4. Poroporoaki - Evaluation and ongoing relationship

Each section begins with a brief summary of the significance of that particular element within the traditional pōhiri process, followed by the relevance of that element in the context of sexual and reproductive health promotion. An explanation of how the element informs and guides sexual health promoters' approach to and interaction with Māori communities is provided.

Case Studies

Promoters shared examples of effective sexual and reproductive health promotion projects and activities. Those examples have been mapped to the elements of the Pōhiri model, so that promoters who are learning to work effectively with Māori communities get a sense of the elements of the Pōhiri model 'in practice'.

1. Pōhiri element



The Pōhiri is a process of engagement within which the tapu[8] of the manuhiri or guests is progressively reduced, to the point where a state of noa[9] exists and host and guests may interact freely and informally.[10]

In the context of sexual and reproductive health promotion, the initial planning phase of an activity or project is extremely important in terms of establishing a platform for respectful, positive engagement. It typically involves promoters getting to know the Māori community they propose to engage with, and gathering relevant information. It also involves promoters becoming fully cognisant of their own core values in relation to sexual and reproductive health and Māori health, and those of the employing organisation. This awareness is vital in helping promoters determine whether or not there is likely to be a good 'fit' with the values and aspirations of the Māori community. Promoters who neglect to identify and reflect upon their own and their organisation's values, experience and reputation may find the metaphorical door to Māori community engagement to be closed!

Cultural safety is a fundamental consideration for any organisation proposing to work with Māori communities.[11] The power that promoters have to facilitate great change or

8 A state of being set apart (Mead, 2003)
9 Balance, or neutrality (Mead, 2003)
10 Mead (2003)
11 Smith (1999); Moewaka Barnes (2000)

foment a lot of damage can be acute in an area of health that may be seen as sensitive. As 'manuhiri' in the pōhiri process, sexual health promoters and their organisations need to 'tread gently';[12] for the community to exercise and uphold their mana as 'tangata whenua' a change in the power relationship is necessary.[13]

Accelerating the development of a culturally competent health sector that understands the lived realities of Māori is an important principle of best practice Māori health promotion.[14] Promoters need to identify and take into consideration the impact of socio-economic disparities and structural barriers that determine poorer sexual and reproductive health outcomes for Māori than for Pākehā. Best practice requires promoters to resist framing activities and programmes in ways that reinforce deficit representations of Māori and perpetuate negative stereotypes.[15] Maori, like any other group, can have diverse cultural beliefs and practices.[16] Some Māori communities draw from traditional Māori understandings of sexual and reproductive health, while others will draw upon contemporary approaches. Best practice involves an acknowledgement that the community's sense of control or ability to practice tino rangatiratanga (self-determination) is essential to a successful health promotion outcome.[17]

During this initial phase, first contact is made with the Māori community. Consider whether there is someone within your organisation or networks who has an existing relationship with the community; who could identify the appropriate person or people within the community with whom to make contact; who could be the point of contact on behalf of your organisation; and, ideally, who could accompany you to the first meeting. It is important to understand, that Māori colleagues who accompany and support you in this way open themselves up to a certain amount of risk. Irrespective of rank or position within the organisation, they will likely be held to a higher degree of accountability by that community than their Pākehā colleague.

In the Pōhiri process, there are obligations to be met by guests (manuhiri) when meeting with the hosts (tangata whenua) for the first time.[18] It is advisable to have someone with you who has the appropriate cultural knowledge to represent you and your organisation. Showing respect is of primary importance; therefore, be wary of making assumptions about the community, their knowledge of sexual and reproductive health, and whether they are open to working with you. Do not presume to speak about the community, let the community speak for itself. Respect the mana of the community and their right to practice self-determination (tino rangatiratanga), and acknowledge

12 Moewaka Barnes (2000)

13 Ratima (2010)

14 Boulton et al. (2011)

15 Borell (2005a)

16 McIntosh (2005); Borell (2005a)

17 Boulton et al. (2011)

18 These include having someone with the appropriate skills to manage the cultural components associated with the manuhiri role and ensure that manuhiri are adequately prepared for the pōhiri ceremony (Mead, 2003).

the knowledge and capability within the community. Whakawhanaungatanga, making links between people, is fundamental to building relationships; during your introduction, any prior engagement between yourself/ your organisation and the community should be acknowledged, and your organisation's intention or purpose stated clearly.

At this stage, the intention should be simply to build a relationship between the organisation and the Māori community - something that takes time, and that should be viewed as a longer-term, ongoing process. Only in the fullness of time can such important values as 'kanohi kitea' (becoming a known face) be realised, and contribute to building trust, credibility and effective health promotion. In relation to kanohi kitea, promoters might consider what engagement they may have with the community beyond their particular professional needs. For example, are there public events of particular interest to that community that a conscientious promoter might enjoy attending? Such events may centre around a local school, marae, sports club or other community group, and attending them not only helps the promoter to become more familiar with the events and prominent people in that community, it also means the promoter is more visible to those community members. Over time this may deepen their sense of trust and continuity with that promoter. Another worthwhile consideration in this context is the importance of pronouncing Māori names of people and places correctly. While most people appreciate a geniune effort in this regard, inaccurate pronunciation tends to mark one as an outsider and can hinder relationship building, particularly in the initial phases.

Case studies: Pōhiri - Planning and relationship-building

Whanaungatanga,[19] an absolutely fundamental value of Māori culture,[20] is key to this phase of the engagement process. There is no one way or 'quick fix' to achieve successful relationships with Māori communities; relationship-building is something that is ongoing and requires commitment. The first step is getting to know the community you are proposing to work with; this requires being proactive in your approach. Identifying who the key community leaders are is vital to understanding, having access to and working with Māori communities.[21] Becoming known to the community (kanohi kitea)[22] is essential to building a relationship based on mutual respect.

Experienced sexual health promoters utilise whanaungatanga and a kanohi ki te kanohi (face-to-face interaction) approach to begin to build enduring relationships with the Māori communities they work with.

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19 The importance of relationships and connectedness.

20 Rangihau (1992)

21 Rochford (1997)

22 Smith (1999)

I find that kanohi ki te kanohi always works best. It's one of those old tried and true things that has worked mai rā anō, and it still works just the same down here. I think that's the best approach, going and having a face-to-face with them.

Whanaungatanga is key for Māori, and at Hui Takataapui that's one of the key elements, building whakawhanaungatanga into the framework of the Hui. It enables takataapui in particular, which is a minority group within the Māori community who are often ostracised or alone, it creates for them a support network and it strengthens them to feel proud of who they are and where they're going in life. And that framework can be used with any group, it doesn't need to be takataapui, it could be rangatahi, it could be pākeke, anyone.

In these promoters' view, the importance of being committed to taking the time, however long that might be, to establish a firm foundation of trust and familiarity upon which to base the relationship, cannot be overstated.

What's the appropriate time that you commit to having that kōrero, getting to know the community? I think we've allowed more and more time as time's gone on, [but] we do just have to [get] stuff [done] so we have to continue that process as we go along. It's that building of trust, to get that information [from the community] that you need to get your programme started.

[The] whole process around whanaungatanga . . . at the start, in terms of giving that time. And it take ages . . . In reality . . . you can spend 6 months on . . . those 'little' things, but they are really massive things.

The nature of that engagement with Māori communities is mostly informal, often taking place in the homes of community members over a cup of tea. During the course of the informal exchange, the promoters are listening to what community members feel are important issues in terms of sexual and reproductive health, and who might be the most appropriate people from within the community to advise or support the kaupapa.

Sometimes . . . it's informal, really informal . . . I'll pop in for a cup of tea and mention, 'Oh, what do you think about this?' And then, 'Oh, let's have a hui about that'. So, start off really informal first, because at that stage I'm going to see what they think, just by their expressions, whether it's something that matters, whether it is something of importance to the community. And often they'll recommend somebody else to talk to about it, or who needs to be involved.

However, that is not where the conversation begins; it begins with whakawhanaungatanga.

Just like natural things that Māori do, you know, someone will walk in the door and you'll automatically ask, 'Who are you?' and 'Where are you from?' . . . [Trust is] key within that relationship building. Once you've got that sorted then you should be

[able] to talk about most things . . . You know, in mainstream[23] sometimes I find it's straight to the 'business'.

I think you do [the whanaungatanga] together [with the sexual health promotion] . . . start the little conversations about what you're up to. But I think too it's how you deliver that kōrero . . . the language [you use], how you use key people within the community in that process, and then for [those key people] to support.

The Peer Sexuality Support Programme (PSSP) is a peer education programme delivered by Auckland Sexual Health Services (Auckland DHB) in 25 secondary schools across the Auckland region. While the community served by the PSSP is not exclusively Māori, it certainly includes Māori. The aim of the programme is to train and support students to disseminate sexual health information to their peers in order to improve sexual health outcomes for young people.

Building good relationships with other students is the basis upon which the imparting of positive sexual health messages by peer educators is facilitated. A number of Māori values, including whanaungatanga and kanohi ki te kanohi, are incorporated into the training programmes delivered by the PSSP trainers. These will in turn be utilised by the peer educators when working with their school communities.

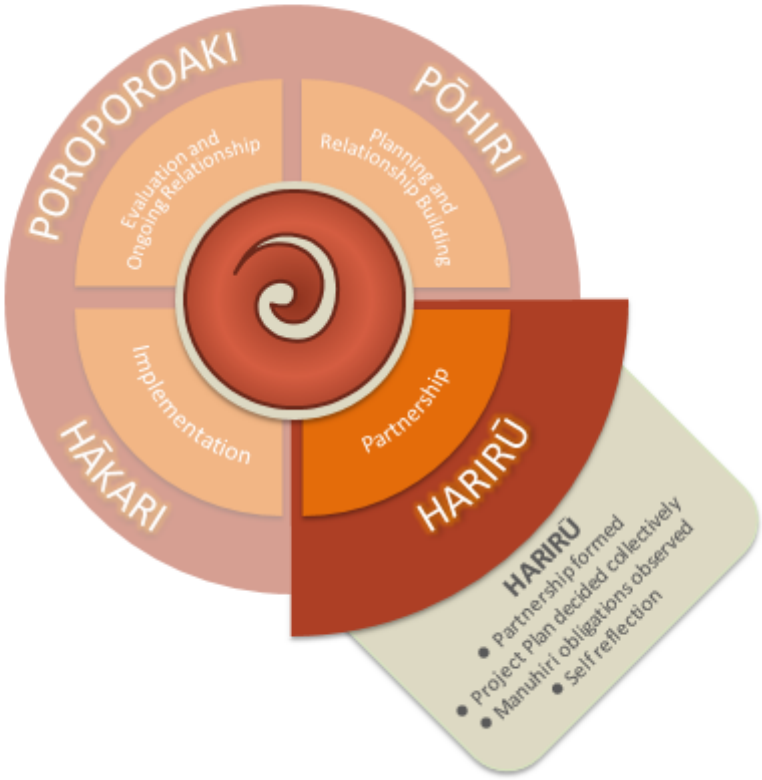
We know they are amazing change-makers in their community. So there's a kanohi ki te kanohi style used, between us as educators and our young people, but also our young people and their peers.

As noted by promoters, the ability to engage effectively with Māori communities is not necessarily an innate quality. It is, however, enhanced by an understanding of the lived realities of Māori and the diversity of cultural identity that can result, an awareness of Māori values and protocols, and a genuine commitment to forging a relationship with that community.

So it's kind of a tricky balance. I think it really depends on your relationship within that community, and your ability to kōrero with that community in a way that connects whānau to the kōrero. I think that's key.

23 In a New Zealand healthcare context, the term 'mainstream' is used to differentiate services that are responsive to the needs of the general public from services that are responsive and accountable to Māori communities.

2. Harirū element



The next phase in the process, the Harirū, involves the manuhiri approaching the hosts' reception line and exchanging hongi. Harirū also represents the concept of hōhou rongo, or making peace, in this case with the tangata whenua.[24]

In the context of sexual and reproductive health promotion, the Harirū corresponds to the more pragmatic phase which focuses on formally establishing a partnership[25] between the Māori community and promoters as representatives of their organisation. Once established, both parties become valued partners in the process of planning and conducting sexual and reproductive health promotion projects within the community. Project aims and objectives, methods and resources, budget, outcomes, and evaluation process are discussed and agreed collaboratively, utilising the expertise of both parties.

By this stage, promoters should be able to identify and account for the structural determinants of sexual and reproductive health as part of the project plan. The plan should contain strategies that foster and promote Māori community control (tino rangatiratanga), and advance Māori values and approaches to sexual and reproductive health.

Recognising each other's value, the promoters' organisation should consider providing koha to Māori community experts involved in the project, and budget accordingly.

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24 Mead (2003)

25 Te Tiriti o Waitangi principles in health promotion, see Martin (2002)

Promoters and their organisations need to be aware that these key community members are likely to be involved in a range of community activities additional to those in health promotion. Therefore, promoters should regularly check to ensure that they are not over-burdening key people. For example, promoters should prioritise engaging key community members for high level strategic support needs, and utilise others for less important operational aspects. Providing koha might also include sharing (de-identified) data that organisations typically collect from clients using their services, including Māori clients. Such data might report the number of Māori using services by age, client satisfaction surveys, trends, and service evaluations.

Promoters should understand that they remain manuhiri within the community throughout the duration of the partnership. Those unfamiliar with working in partnership with Māori communities are encouraged to ensure their obligations as manuhiri are constantly maintained and, when in doubt, to seek advice.[26] Promoters should utilise their professional bodies, their supervisors, or (in the case of DHB promoters) their Māori health management unit for cultural advice and support. If promoters require assistance but their organisation does not provide Māori cultural advice and support, consideration should be given to referring the activity or project to another sexual and reproductive health promotion organisation. It is worth considering that health promotion projects that go horribly wrong can cast a long shadow over the health organisation, to the extent that rebuilding relationships with Māori communities can take many years.

Case studies: Harirū - Partnerships

Partnership commonly refers to a contractual agreement between two or more parties, with connotations of joint interest, sharing and cooperation. From a Māori perspective, the Treaty of Waitangi is a potent symbol of partnership (rangapū) between Māori and the Crown, where each party has an important part in the relationship and both strive for more equitable outcomes.[27] This view aligns with the principle of partnership promoted in 'He Korowai Oranga', where government agencies and services work collaboratively with iwi, hapū, whānau and Māori communities to plan, deliver and evaluate Māori community-responsive services.[28] Features of good partnership include: the community retaining a sense of ownership and control of the project (tino rangatiratanga); the enhancement of cultural identity as understood by that particular

26 Good sources of advice include experienced Māori health promoters in one's own organisation, the relevant professional body, or PASHANZ (Promoters of Sexual Health in Aotearoa NZ).

27 In the Te Aka Online Māori Dictionary under 'rangapū', Te Ururoa Flavell describes the Treaty as being 'like a partnership . . . the partnership between Pākehā and Māori encourages us both to remain true to equality.'

28 Ministry of Health (2014)

Māori community;[29] organisations implementing the principles of the Treaty of Waitangi; and collaborations between organisations and Māori communities that incorporate the expertise and leadership of key people from within those communities.

An example of effective partnership between a national mainstream organisation and Māori communities is provided by the sexual health promotion initiative known as Hui Takataapui. A biennial event that has been running in Aotearoa New Zealand for 28 years, Hui Takataapui operates today as an identifiably Māori, community-driven event that is supported by the New Zealand AIDS Foundation (NZAF). A major strength of that partnership is that while the NZAF provides assistance and financial support, the Māori community retains ownership and control (tino rangatiratanga) of the event.

> *Our role as kaimanaaki is to assist that iwi to run the Hui Takataapui . . . [to] develop a committee of people that will work to run, organise and implement the Hui. This model is all about building leaders, developing our people . . . it's about handing the event over to the people to run . . . Our [Māori] people know how to work with their own, they don't need us to tell them how to do it. So we are there merely to provide the support, the tautoko, and the financial support that they need*.

NZAF aims to support Māori community engagement in order to achieve the goal of building HIV-resilient, healthy, strong communities.

> *In essence what we're really trying to do is empower our community, and for them to understand our kaupapa and practice safe sex . . . Changing their behaviour is about their self-esteem, building their Māoritanga, lifting them, through waiata, haka, being on the land, listening to the kaumātua. If that's going to empower them to learn about themselves, that's a much better tool and use of our time within the Hui*.

Promoters in Māori communities tell us that identifying and utilising key members of the community is central to building a partnership with that community. However, achieving sustained Māori wellbeing requires collaborative cross-sectoral approaches between sexual health promoters, organisations in the health and social sectors, and Māori communities.

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[29] See McIntosh (2005) and Borell (2005a, 2005b) for a discussion of the complexity of Māori identities.

3. Hākari element

The Hākari is a ritual feast provided by the hosts, during which the tapu attendant on the manuhiri becomes neutralised through the consumption of food.

In the context of sexual and reproductive health promotion, the Hākari corresponds to the practical implementation of the project as agreed in partnership with the Māori community and described in the project plan. It is critical within this phase that the most appropriate person or people[30] undertake to conduct the project activities that involve working with the Māori community. Less experienced promoters might take 'back stage' support roles, leaving Māori community representatives to lead the project. After all, the goal of effective Māori health promotion is for tino rangatiratanga - where communities sustain and incorporate health promotion activities into their day-to-day lives, beyond the duration of finite health promotion projects. However, care must be taken to ensure that ongoing health promotion costs can be met from appropriate funding sources. Promoters should understand that they are accountable to the Māori community with whom they have built a partnership[31] as well as to their employing organisation.

30 This refers to the most appropriate person or persons in terms of gender, age, ethnicity and sexual orientation, e.g., takataapui health promoters working with takataapui communities; Māori working with Māori; young people working with youth; and so on.

31 Moewaka Barnes (2000); Smith (1999)

As in the Pōhiri and Harirū phases, promoters working with Māori communities are encouraged to maintain a process of self-reflection with regard to meeting obligations, and to seek advice and assistance when required.

Case studies: Hākari - Implementation

When working with Māori communities, it is imperative that sexual health promotion projects and activities are implemented in accordance with what has been agreed in partnership with the community. This is one aspect of accountability inherent in the partnership that promoters and their organisations need to be aware of. Transparency of information, consistent visibility and consistent health promotion messages are all important features of good implementation.

> *And always having that open relationship and making sure you're keeping transparent within our communities*.

Sexual health promoters reported that Māori health models are invaluable when working with Māori communities. By studying the principles embedded in those models, promoters are more likely to be able to connect with Māori communities.

However, a more intangible element identified as enhancing the successful delivery of sexual and reproductive health promotion is an attitude of genuine empathy and caring for the community you are working with, and a sensitivity toward the material and its significance to Māori.

> *[It's about] the extra things, like having the heart, [being] ngākaunui for the mahi, and the empathy. It's also about being aware, and utilising those [health promotion] models . . . and knowing that they've been made and developed by a Māori person with Māori people at heart*.

For sexual health promoters who have a number of years experience working with Māori communities, it is helpful to be familiar with more than one Māori health model. Experienced promoters can select the model that they think is best suited to a community. They might choose a model that is already familiar to the community, or they might modify that model to improve the match with the community or with the issue to be discussed.

> *If it's for a school we use Te Whare Tapa Whā, because it's what they know in the curriculum and it's easy for them to follow. However, I do like using Te Pae Mahutonga because it's got that little bit extra, especially when we are looking at the environment, who are our leaders that we look to, and that type of thing. It really all depends on what type of resources and what the mahi is for. I will look at my key audience and then decide what model I'll use. If it's for the Wharekura . . . I'll look at Te Aho Matua. I will design something that fits in with things they are already working with. So it's about the key audience and whether it's going to fit [for] them*.

Ensuring that the choice of model and the delivery of the model is relevant and engages the audience is important, as is a willingness to review and improve one's own process and approach. This highlights the extent to which sexual health promoters working with Māori communities need to feel accountable to, and be dedicated to achieving positive, transformative outcomes for those communities.

> *With Te Whare Tapa Whā, I wouldn't just put a picture up on the wall and say, 'Well you've got these four walls in your Whare Tapa Whā and if one falls down then you won't be well'. I would actually give a meaningful example . . . [one] that is meaningful for them and has relevance at the time. So we talk about sexual health as something that is about you, but not only about you. It's about looking after yourself, your whānau and your communities. Especially your mates if there is alcohol involved . . . So making it meaningful, using things that are relevant to them, that they can connect to*.

> *What I've found with resources is, I don't need to make it harder, so I keep to what they are familiar with, working alongside what's already in place and modifying our mahi to fit in with them. We have to be flexible*.

In connection with this, PSSP exemplifies the notion that young people can be effective when working with other young people in the promotion of sexual health. Young people may be better equipped to understand the norms, activites, language and technologies most relevant to their peers.

> *The health promoters are led and driven by the students themselves: they decide what they feel are the issues at hand for their school and they address them in ways that they feel are appropriate, not just for young people but for the young people in the communities they engage with on a regular basis*.

In some cases, particularly where a key objective may be to reconnect Māori with their cultural identity, experienced sexual health promoters may choose to utilise the direct experience of immersion in Māori cultural practices rather than theoretical health models.

> *Our focus has moved more towards not necessarily utilising health models. It's about getting back to basics, getting back to tikanga Māori, as us, and obviously getting back on to the marae – the tikanga of marae, the pōhiri and all that, but it's more around just being on the marae, being with the mana whenua, learning from our elders and being embraced by te ao Māori . . . So providing the setting for our young Māori to be embraced within is key to getting our kaupapa to them. And once they're in that environment . . . you can empower them and connect them to one another*.

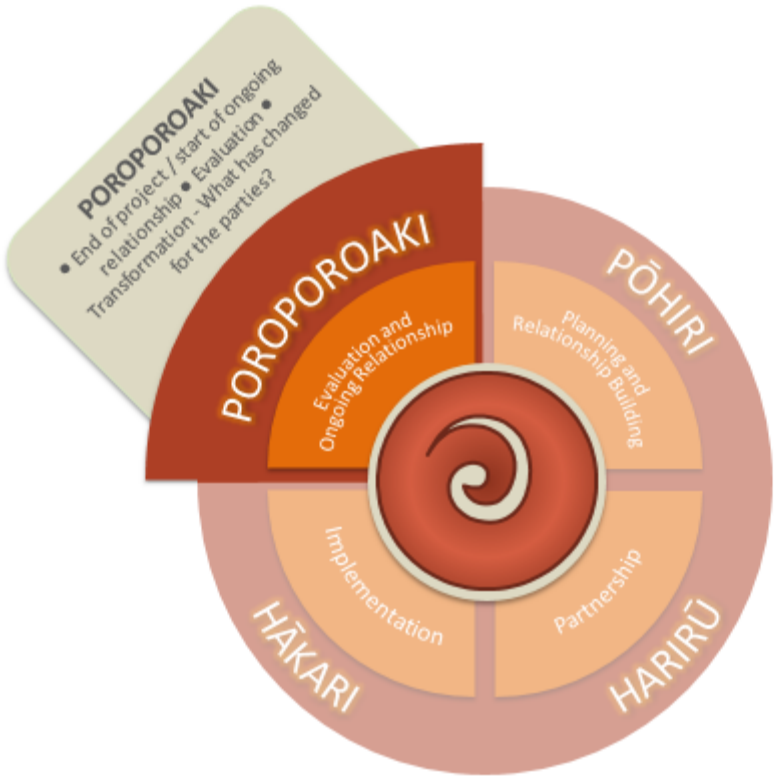
The marae is considered an important setting to facilitate wānanga or learning that incorporates Māori language, values and concepts. The marae gives hui participants the opportunity to experience the spiritual aspects involved in cultural processes such as

pōhiri, karakia and poroporoaki. The marae also provides a space within which young people may feel safe to discuss issues around sexuality.[32]

> *We try and open the space in a safe way for our young people and the best way for us to do that is through a pōwhiri process . . . following the protocols of our tangata whenua and opening the space up for our young people and inviting them into our world. I think it's the most important way to actually see young people walk into a sexual health space . . . It's not just straight off the bat about sex; it's that we actually see you as a whole person and we want to invite all of you in*.

[32] For some communities, however, non-marae settings may also be important and relevant and these should be explored and discussed in the planning stages to ensure that people's experiences of sexual health promotion are positive, embracing and transformative (McIntosh, 2005; Borell, 2005a, 2005b)

4. Poroporoaki element



The Poroporoaki is a ritual leave-taking at the close of the pōhiri process that involves speeches of farewell and appreciation shown by the manuhiri to the tangata whenua. While the pōhiri ceremony itself may be over, a transformational process has occurred inasmuch as the Poroporoaki signifies the beginning of an ongoing relationship between the Māori community and the sexual health promotion organisation.

Evaluating the health promotion project is as important as planning and delivering the project. Promoters and Māori communities should plan the evaluation at the same time as they are planning the aims and objectives of the project. Consideration should be given to conducting process and outcome evaluations as a minimum. The process evaluation provides parties with information about the quality of the planned project activities, the use of resources, and the adequacy of the timeframes (i.e., how many did we do, and how well did we do them?). The outcome evaluation provides the parties with critical information about whether the aims of the project were achieved (i.e., was the Māori community any better off?).

As a result of the Pōhiri process of engagement and partnership, the intention is that the Māori community is better placed to foster and maintain improved sexual and reproductive health, and that disparities and structural barriers have been addressed and some type of positive structural transformation is underway. Furthermore, there is an expectation, captured in the evaluation, that the parties have also undergone a positive process of transformation. For health promoters, they should gain new skills and knowledge as well as new insights and an appreciation for the breadth and depth of

knowledge that exists within Māori communities. The transformation for organisations should be of a strategic nature in terms of the principles of the Treaty of Waitangi and providing policy advice at national and regional levels, and operational from the point of view of addressing the needs of Māori communities, meeting funder requirements and building an informed workforce.

Case studies: Poroporoaki - Evaluation and ongoing relationships

The Poroporoaki is the final ritual in the Pōhiri process of engagement and transformation. It is important to understand that while the Poroporoaki signifies the conclusion of the pōhiri, it does not mean the end of the relationship between host and manuhiri. From a Māori perspective there is much value in maintaining ongoing positive, reciprocal relationships that are mutually beneficial. From another perspective, the promoters and their employing organisations now have an obligation of accountability[33] to the Māori community that extends beyond the bounds of the project.

One aspect of that accountability is ensuring that the benefits of the project can be sustained. The organisation should ensure sufficient resources and support are available to the community to sustain them in the long term.

> *In terms of follow up after hui . . . strengths based approaches are very important to us. So when the students go back into their schools they're expected to come to our fortnightly . . . supervision meetings, to see that they have the right support and everything they need to support their peers, especially if there are any major disclosures or anything we need to help with*.

In terms of the transformation element, some sort of evaluation can be usefully conducted at the conclusion of a sexual health programme or activity in order to assess the short and longer-term nature of the transformation (e.g., observation, discussion at poroporoaki, feedback forms). Ideally, transformative changes will be structural (longer-term) and operational (short-term) and evident to both partners - the Māori community and the sexual health promotion organisation.

> *It can actually be quite intense . . . Over the four days that you're at the hui you're creating a whole new culture and identity that is generally unlike what [the young people] are used to in . . . their normal environments. And so we're aware that these young people are going through life-transforming experiences at the hui*.
>
> *Being a mainstream organisation, sometimes, without even knowing it, we may have Māori as the key focus [of the programmes but] it will still have elements of mainstream Pākehā. I think up here in terms of delivery we still have a lot of work to do, connecting with Māori a lot better, especially in terms of [sexual and*

33 Moewaka Barnes (2000)

reproductive health]. We are always looking at how we can do it better; we are always recreating, recreating, trying to figure out where we are at.

Accountability to Māori communities requires health promoters to plan and evaluate for structural change.

> *[We] start with ourselves and how we work within the [mainstream] organisation. In order for us to work with our people we needed to make sure that our whare was right . . . We have a Kaiārahi role and a Kaimahi Community Engagement Coordinator Māori, and a Social Marketing/Coordinating Māori role that work within the organisation. We also thought that it was important for us to have a voice . . . on the NZAF Board of Trustees, so we set up Te Roopū Kia Tau, a Māori advisory board who I sit alongside, and that is to ensure that the Māori voice is heard from a governance level through to operational. And that makes any initiatives that we do a lot easier, when you have that tautoko, that manaakitanga from the top to the bottom*.

Structural change within organisations is important, but structural change that addresses the broad determinants of poor sexual and reproductive health in Māori communities is critical to achieving sustained health transformations. Policy submissions, media campaigns, social marketing, and supporting Māori community action to tackle disadvantage are all important sexual health promotion activities.[34]

34 Ottawa Charter (World Health Organisation,1986)

Conclusion

Mana Tangata Whenua: National Guidelines for Sexual and Reproductive Health Promotion with Māori has been developed to assist health promoters and their organisations to plan and deliver effective, Māori community-responsive sexual and reproductive health promotion, in partnership with Māori communities. The process of developing the Guidelines has been consultative and collaborative, and grounded in the principles of Kaupapa Māori. Underpinning the Guidelines is research-informed literature and the perspectives of experienced sexual health promoters working with Māori communities.

At the heart of the Guidelines is the Pōhiri model, a framework for sexual and reproductive health promotion. Derived from Māori values and protocols, the Pōhiri model describes the characteristics of successful sexual and reproductive health promotion with Māori. The core components of the model include facilitating respectful engagement, building enduring mana-enhancing relationships, and effecting transformative outcomes – for Māori communities in the first instance, and also for promoters and organisations themselves.

The model sets out the obligations and accountabilities that promoters and their organisations need to address in their role as manuhiri working in partnership with Māori communities. These include working towards effecting transformation by:

- increasing Māori community control over their own health;
- advancing Māori values and approaches to sexual and reproductive health, and
- creating transformational change at the structural level in order to address and remove the barriers to Māori community health and wellbeing.

The result is a Guidelines that brings together the best of theory and practice of good sexual and reproductive health promotion with Māori communities.

Development of the Guidelines

Kaupapa Māori approach

A Kaupapa Māori approach was used to develop and shape the content of the Guidelines. Kaupapa Māori is an approach that draws from traditional and contemporary Māori knowledges and worldviews. In the health sector, a Kaupapa Māori approach aims to increase Māori community control of health, validate the importance of Māori language and culture, and transform structures that are a barrier to Māori community and individual health and wellbeing.[35]

The Kaupapa Māori approach was chosen because research shows that Māori community control of health promotion programmes and activities is associated with better health outcomes.[36] Further, health promotion programmes and activities that foster and promote te reo Māori and tikanga Māori content are more likely to resonate with Māori communities.[37] Last, the determinants of Māori health are largely dictated by the socio-economic structures that exist across the sectors of government and which act to create barriers to good health. Therefore, improving Māori sexual and reproductive health outcomes requires an approach that transforms the structures and removes barriers, in order to advance Māori health.[38] Kaupapa Māori shares some common ground with conventional health promotion; however, inasmuch as the approach seeks to empower Māori communities and reorient structures, Kaupapa Māori is grounded in distinctly Māori ways of achieving health and wellbeing.

Methods

Consultation

Te Whāriki Takapou consulted the national network for sexual health promoters (PASHANZ) about the project aims, outcomes and processes. Experienced promoters were invited to contribute case studies and lessons learned about working with Māori communities. Once drafted, the Guidelines was piloted with promoters working for a 'mainstream' sexual and reproductive health organisation and, based on evaluation and feedback, changes were made to the document structure and content. Next, the revised draft was sent to a Māori health promotion expert for external review.

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35 Nepe (1991); and Pihama (2001)

36 Durie (2004, referred to in the Te Pae Mahutonga model as Mana whakahaere); see also Boulton et al. (2011).

37 Te reo is integral to gaining 'access to the Māori world' and 'identity as Māori', Ratima (2010); Durie (2004)

38 Referred to in the Te Pae Mahutonga model (Durie, 2004); also Ratima (2001).

Annotated review

Recent research-informed, peer-reviewed publications about Māori models of health promotion and sexual and reproductive health promotion in Māori communities were annotated. Publications were purposefully selected on the basis that:

1. The voices of Māori communities was central to the publications, with a number of the authors being Māori;
2. Māori language and concepts featured prominently in the models and publications; and
3. The research findings sought to be transformative, i.e., consider and where possible address structural barriers to good health for Māori peoples.

Case studies

Experienced promoters were interviewed about examples of effective sexual health promotion programmes and activities with Māori. Four case studies were compiled using face-to-face and telephone interviews, during which promoters shared key learnings of benefit to sexual and reproductive health promoters.

Health promotion

Māori health promotion is defined by Ratima[39] as 'the process of enabling Māori to increase control over the determinants of health and strengthen their identity as Māori, and thereby improve their health and position in society'. Health promotion ranges from micro-level approaches that involve educating individuals about how to improve their health, to macro-level approaches that seek to introduce legislation and policies in order to effect structural change.[40] The World Health Organisation (WHO) Ottawa Charter provides an international common understanding of health promotion theory and practice, influencing health promotion in Aotearoa New Zealand.[41]

Māori approaches to health promotion are based upon well-known models such as Te Whare Tapa Whā, Te Pae Mahutonga, Te Wheke, and Kia Uruuru Mai a Hauora.[42] Reference has been made to some of the components of these models, in particular those that can make a significant contribution to sexual and reproductive health promotion with Māori communities.

Māori and health in Aotearoa New Zealand

At 509,605 in 2013, Māori made up 14.9 percent of the New Zealand population,[43] constituting a very youthful population with a median age of 23.1 years, 13.7 years younger than that of the total population.[44] A third of the Māori population is under 15 years of age.[45]

In 2001, data show that over 84% of Māori resided in urban areas and 16% in rural areas.[46] Three percent of Māori in Aotearoa New Zealand live in high-decile (least deprived) neighbourhoods, while 24% live in the lowest decile (most deprived) neighbourhoods, compared to 7% of non-Māori.[47] Aotearoa New Zealand is made up of at least 98 different iwi,[48] with diverse dialects and cultural protocols. The recent Te

39 Ratima (2010, p. 8)

40 Barton (2014)

41 World Health Organisation (1986)

42 Durie (1998, 1984); Durie (1999); Pere (1984); and Ratima (2001) respectively

43 Statistics New Zealand (2013a)

44 Statistics New Zealand (2011)

45 Statistics New Zealand (2013b)

46 A complete reversal from 1926 when 16% of Māori lived in urban areas and 84% in rural areas (Statistics New Zealand, n.d.)

47 Ministry of Health (2014)

48 Te Puni Kokiri (n.d.).

Kupenga 2013 study (2014a, 2014b) found that 55% of Māori were able to speak some te reo Māori and 70% of Māori felt that involvement in Māori culture was important.[49]

Health organisations that are government-funded are required to plan and deliver services that meet the needs of their communities. The needs of Māori communities are not always accurately identified because some health planners assess the needs of the whole population, and overlook the particular needs and aspirations of Māori. Other health planners fail to account for the health disparities that exist between Māori and non-Māori populations, despite the fact that addressing disparities is a requirement of government health funding.

Health disparities information is important when it comes to allocating scarce sexual and reproductive health resources to populations most at need. The sexual and reproductive health disparities between Māori and non-Māori are long-standing.[50] Up-to-date needs assessment information and disparities data are, therefore, critical tools for organisations that want to allocate sexual and reproductive health promotion services where these are most required and most likely to reduce disparities.

Māori and sexual and reproductive health

There is a dearth of research about sexual and reproductive health in Aotearoa New Zealand, particularly in relation to Māori. While it is acknowledged that there are issues with the accuracy of ethnicity data in Aotearoa,[51] what is available suggests wide inequalities in the burden of sexually transmitted infections (STIs) for Māori, particularly among the most 'at risk'[52] age group of 15 to 25 years.[53]

A lack of comprehensive national datasets masks inequalities in STIs and their sequelae;[54] however there are indications that the patterns of STIs differ between Māori and other New Zealanders, specifically with regard to chlamydia and gonorrhoea. For example, while the rates of chlamydia and gonorrhoea among all young women is high, Māori experience high rates among both young women and young men. Furthermore, young Māori men are less likely to seek or be offered sexual health care.[55] It has been suggested that STI inequalities for Māori are due to structural factors including poor

49 Statistics New Zealand (2014a; 2014b)

50 Copland, Denny, Robinson, Crengle, Ameratunga, & Dixon (2011); Institute of Environmental Science and Research (2014)

51 Harwood (2010)

52 Borell (2005a) warns that health promotion may sometimes reinforce a deficit framing of Māori, particularly of Māori young people.

53 Sherwood (2006); Terry et al. (2012); Rose et al. (2012)

54 Terry et. al. (2012)

55 Morgan and Haar (2008)

access to low or no-cost, culturally appropriate, youth-friendly STI information and services.[56] [57] [58]

Unlike data for other STIs, Māori are not overrepresented in the number of people living with HIV and AIDS. Diagnosis data show that at the end of 2013 an estimated 3952 people had been diagnosed with HIV/ AIDS in Aotearoa New Zealand. Since 1996 when information on ethnicity was collected, approximately 7% of those diagnosed with HIV/AIDS were Māori. Of those diagnosed with HIV/AIDS since 1996, the percentage of Māori males has decreased slightly while the percentage of Māori females has slightly increased.[59] HIV prevention messages and activities that target Māori 'at risk' groups, are developed in partnership with Māori, and delivered by Māori. Data and anecdotal evidence suggest that efforts to prevent an HIV/AIDS epidemic in Māori communities have been effective. However national action is required to end HIV-related stigma and discrimination in New Zealand, including Māori communities.

While understanding and tolerance of sex and gender diversity in Aotearoa New Zealand has increased over the last decade, more needs to be done to eliminate racism, misogyny, homophobia, transphobia and stigma and discrimination associated with sex-, sexuality-, sexual orientation- and gender-diverse groups within Māori communities.[60]

Regarding contraception, Māori communities require accessible, high quality, low cost contraceptive services delivered by health professionals trained to deliver services that match Māori values and norms. Informed choice, not coercion must be the gold standard by which contraceptive methods, including long-acting reversible contraceptives (LARCs), are offered to young Māori women. The New Zealand Health and Wellbeing surveys of secondary school students found that all sexually active students reporting always using contraception remained at around 60%, a rate that was amongst the lowest for developed countries.[61]

A recent report on current trends for teenage pregnancy shows that while the teenage birth rate for Māori has always been higher, the rate for Māori is declining at the same rate as for the total population of Aotearoa New Zealand. This mirrors the overall declining teenage birth rates in Australia, Canada and the United States, suggesting the influences on teenage births are global.[62] The decline in the Aotearoa New Zealand rate for all teenage births may be a consequence of delayed sexual activity among teenagers, as studies involving school-aged teenagers found little evidence of increased contraceptive use.[63] A recent report for the New Zealand Families Commission suggests

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56 Rose et al. (2012); Terry et al. (2012); King (2014); Waiti & Green (2014)

57 Ministry of Health (2008)

58 Morgan (2013)

59 AIDS Epidemiology Group (2014)

60 Te Puni Kokiri (1995); Hutchings & Aspin (2007); Nikora and Te Awekotuku (2013)

61 Clark et al. (2013), cited in NIDEA (2015)

62 NIDEA (2015)

63 Clark et al. (2013)

a link between higher regional rates of teenage births and poor access to health services, educational and employment opportunities.[64]

Māori, in particular rangatahi Māori, are disproportionately represented in negative sexual and reproductive health statistics such as STIs[65] and reproduction.[66] Access to comprehensive, culturally appropriate sexuality education programmes that provide accurate information and opportunities for skill-building are critical. Research[67] has highlighted shortcomings in the provision of sexuality education in New Zealand schools, some of which has little relevance for Māori communities.[68] The perspectives of rangatahi, including rangatahi takataapui, whānau Māori, teachers and communities must be incorporated into the development and delivery of sexuality education programmes and resources to ensure these resonate for Māori.

Socio-economic determinants and the Treaty of Waitangi

Health disparities between Māori and other New Zealanders are a consequence of colonisation and the distribution of the social and economic determinants of health in Aotearoa New Zealand.[69] Factors such as income, employment status, education, housing, and social position have a deleterious impact on the health of Māori individuals and communities.[70] Māori communities are more likely to be those living in areas of high deprivation[71] which contributes negatively to their overall wellbeing, reduces the likelihood of satisfactory housing, a good education, adequate healthcare[72] and good sexual and reproductive health.[73]

A consistent Māori response to the socio-economic determinants of poor health has been to advocate for the principles of the Treaty of Waitangi as the basis for equitable social and economic resources across all sectors of government.[74] Measuring the socio-economic disparities between Māori and other New Zealanders provides a mechanism for monitoring the government's performance in meeting their Treaty of Waitangi obligations to Māori. Health funders and sexual and reproductive health organisations

64 NIDEA (2015)
65 Institute of Environmental Science and Research Ltd (2014)
66 Crengle et al. (2013)
67 Fenton, 2012; Fenton & Coates, 2008; Abel & Fitzgerald, 2005; Allen, 2005
68 Families Commission (2013); Education Review Office (2007)
69 Robson (2004)
70 Robson & Harris (2007)
71 Ministry of Health (2014)
72 Ministry of Health (2010)
73 Rochford (2004)
74 National Health Committee (2002)

share obligations to Māori communities to plan, deliver and evaluate services on the basis that these are responsive to Māori community needs and reduce disparities.

Health funders and sexual and reproductive health organisations are also required to plan and deliver services according to the principles of partnership, participation and protection. The overarching government policy 'He Korowai Oranga'[75] provides a Treaty-based framework to guide all organisations to address these principles and achieve the best health outcomes for Māori. In the sexual and reproductive health sector this might mean:

Partnership - Working with iwi, hapū, whānau and Māori communities to plan, deliver and evaluate Māori-responsive sexual and reproductive health services;

Participation - Involving Māori at all levels of the sexual and reproductive health sector (i.e. policy, data collection, planning, funding) and within sexual and reproductive health organisations (i.e. governance, service delivery, workforce development);

Protection - Reducing sexual and reproductive health disparities, and fostering and promoting te reo Māori, tikanga Māori, and Māori values and practices in sexual and reproductive health service planning and delivery.

Māori and sexual and reproductive health promotion

Māori language and culture, te reo Māori and tikanga Māori, lay the foundation for good sexual and reproductive health promotion. Unfortunately myths abound about sexual and reproductive health and Māori. One myth is that Māori don't talk about sexual and reproductive health because such matters are tapu! Anyone who regularly attends hui and has a reasonable knowledge of te reo Māori, knows that matters to do with sexual and reproductive health are topics that are regularly touched upon in the course of formal oratory, or whaikōrero, and will also be part of good-natured humour in relaxed social settings. Some older Māori with a deep knowledge of te reo Māori and tikanga Māori know that pre-Christian pūrākau, waiata, haka, mōteatea and whakairo extol and indeed celebrate sexuality, relationships, and reproduction.[76] Recent studies confirm that it is Christianity and Victorian values, not Māori culture, that has suppressed talk about sexual and reproductive health, and marginalised Māori understandings of sexuality, relationships and reproduction.[77]

75 Ministry of Health (2014)

76 Karetu (1997)

77 Aspin (2014); Simmonds (2014); Murphy (2013); Gabel (2013)

Models for Māori sexual and reproductive health promotion

There are a number of models available to health promoters to use in engagement, development and delivery of sexual and reproductive health promotion with Māori communities. The models referred to in these Guidelines all incorporate concepts - usually metaphoric in nature - that are familiar to Māori.[78] What follows is a brief description of these models, some of which are utilised in sexual and reproductive health: Te Whare Tapa Whā, Te Pae Mahutonga, Te Wheke, and Kia Uruuru Mai a Hauora. Promoters who are new to working with Māori communities are encouraged to work with a model, preferably with the support and advice of a more experienced colleague or professional advisor. More experienced promoters may wish to draw from more than one model. They might choose components from more than one model on the basis that some components are better suited to addressing certain issues and challenges, therein achieving a more well-rounded approach and outcome.[79]

Te Whare Tapa Whā

Developed in 1982 by a group of Māori health workers, including the author, Mason Durie,[80] and designed in response to the need to address health disparities experienced by Māori,[81] Te Whare Tapa Whā promotes a unified, holistic view of health. The whare depicted in the model symbolises a wharenui with a strong foundation and four equal sides that represent four dimensions of Māori wellbeing: Te Taha Tinana (Physical), Te Taha Hinengaro (Mental and Emotional), Te Taha Wairua (Spiritual) and Te Taha Whānau (Family, or extended family). Should any one of those dimensions be missing or in some way damaged, a person or a collective may become unbalanced and unwell. The Te Whare Tapa Whā model is implemented in policy settings, personal health assessments, and the development of community activities and projects.

Te Pae Mahutonga

Te Pae Mahutonga[82] is a representation of the Southern Cross constellation, recognised as a key navigational point that guided Māori and Pacific navigators on their voyages back and forth across the Pacific Ocean. Te Pae Mahutonga is made up of 4 points: Mauriora (connection to cultural identity), Waiora (quality of connection to the surrounding environment), Toiora (healthy lifestyles free of risk) and Te Oranga

78 Suaalii-Sauni et al. (2009)

79 Ratima (2010); also Nikora et al. (2001)

80 Durie (1984, 1998)

81 Rochford (2004); see also Simmonds (2014); and Gabel (2013). See also Mikaere (1995)

82 Durie (1999)

(participation in society); as well as two important prerequisites to health, Ngā Manukura (strong community leadership) and Te Mana Whakahaere (commitment to tino rangatiratanga). An example of Te Pae Mahutonga in action is the strategic framework developed by the Northland District Health Board to guide public health action in Northland.[83] The model promotes a comprehensive approach to affirming the fundamentals of good public health for Māori *and* non-Māori populations alike in the Northland region.[84]

Te Wheke

Te Wheke, the octopus, symbolises the interdependence of all things: the head of the wheke represents the whānau; the eyes represent 'waiora' or total individual and whānau wellbeing; and each of the eight tentacles represents a specific dimension of health - Wairuatanga (spirituality), Hinengaro (the mind), Taha Tinana (physical wellbeing), Whanaungatanga (extended family), Mauri (life force in people and objects), Mana Ake (unique identity of individuals and family), Hā a Koro mā a Kui mā (breath of life from forebears), and Whatumanawa (open and healthy expression of emotion). Each tentacle is conceptualised as moving out in an infinite direction as the Wheke seeks sustenance; the tentacles are also able to be intertwined to create an interdependent whole. Te Wheke,[85] developed by Dr Rangimarie Turuki Pere, is a useful model for representing the facets and dimensions of Māori communities, whānau, healing and health, the inter-relationships as well as the context of the whole. Rhys Jones describes traditional Māori healing as fitting the Te Wheke model because it successfully accommodates the cornerstones of healing.[86]

Kia Uruuru Mai a Hauora

The Kia Uruuru Mai a Hauora framework was developed by Mihi Ratima[87] and is strongly focused on addressing the structural determinants of health, reorienting health systems and organisations, and achieving individual and collective health and wellbeing. However, how the determinants are addressed and what changes are made to health systems and services must all be underpinned by Māori values, practices and concepts of good health. As a minimum, best practice health promotion will be consistent with Māori worldviews, embrace a holistic concept of health, incorporate a focus on Māori identity, facilitate increased control by Māori over the determinants of health, and lead

83 Northland District Health Board (2009)
84 Durie (2004)
85 Pere (1984)
86 Jones (2000)
87 Ratima (2001)

to Māori-centred health gains.[88] Helpfully, the framework identifies markers of successful health promotion with Māori. These are: secure Māori identity, improved health status, beneficial health determinants, and strengthened Māori collectives.

88 Ratima (2001)

Glossary

Aroha ki te tangata	Respect for people
Haka	Traditional dance; to perform haka
Hākari	A sumptuous meal; a feast
Hapū	Kinship group, clan or sub-tribe
Harirū	To shake hands
Hōhou rongo	To make or cement peace
Hongi	To press noses in greeting
Iwi	Extended kinship group or tribe
Kaiārahi	Leader, mentor, guide
Kaimahi	Worker or employee
Kaupapa	Topic or matter of discussion; issue
Kanohi kitea	A seen face; recognised, familiar
Kanohi ki te kanohi	Face-to-face
Koha	Gift, contribution, with connotation of reciprocity
Kōrero	Information, narrative; to say, tell, speak, discuss
Mai rā anō	For a long time; from long ago
Mana	Power; influence; prestige
Manaakitanga	Generosity and care for others
Manuhiri/manuwhiri	Visitor; guest
Mōteatea	A lament or traditional chant
Ngākaunui	To be eager; enthusiastic
Pakeke/pākeke (pl.)	grown up, adult, mature
Poroporoaki	To take leave of; farewell; a eulogy
Pōhiri/pōwhiri	Welcome ceremony
Pūrākau	Traditional stories, narratives

Tapu	Be restricted; set apart; under atua protection; sacred (modern)
Tangata whenua	Local people; hosts; indigenous people
Tautoko	Support, backing
Te Aho Matua	The philosophical base of Kura Kaupapa Māori education
Te reo Māori	The Māori language
Tikanga Māori	Māori cultural practices and values
Tino rangatiratanga	Self-determination; sovereignty; autonomy
Tono	To request; invitation
Waiata	Song; to sing
Wānanga	To impart knowledge; to meet and discuss; deliberate
Whakairo	Carving; to carve, ornament with a pattern
Whakapapa	Genealogy; to recite genealogies
Whānau	Family; extended family
Whanaungatanga	Kinship; a relationship through shared experiences
Whare	House, dwelling, building
Wharekura	House of learning; a secondary school run on kaupapa Māori principles (modern)
Wharenui	Meeting house
DHB	District Health Board
NZAF	New Zealand AIDS Foundation

References

Abel, G., & Fitzgerald, L. (2005). 'When you come to it you feel like a dork asking a guy to put a condom on': Is sex education addressing young people's understandings of risk? *Sex Education*, *6*(2), 105–119.

AIDS Epidemiology Group. (2014). *AIDS New Zealand Newsletter* (June ed.). Dunedin: Dunedin School of Medicine, University of Otago.

Allen, L. (2005). 'Say everything': Exploring young people's suggestions for improving Sexuality Education. *Sex Education: Sexuality, Society and Learning, 5*(4), 389-404.

Aspin, C. (2014). *Hōkakatanga- Māori sexualities- Early Māori sexualities*. Retrieved from http://www.TeAra.govt.nz/en/hokakatanga-maori-sexualities/page-2

Bardach, E. (1998). *Getting agencies to work together: The practice and theory of managerial craftmanship*. Washington, DC: Brookings Institution Press.

Barton, G. (2014). *Health promotion settings - An opportunity to improve health*. Auckland: Health Promotion Forum.

Borell, B. (2005a). *Living in the city ain't so bad: Cultural diversity of South Auckland rangatahi* (Master's thesis, Massey University, Auckland, New Zealand).

Borell, B. (2005b). Living in the city ain't so bad: Cultural identity for young Māori in South Auckland. In J. Liu, T. McCreanor, T. McIntosh, and T. Teaiwa (Eds.), *New Zealand identities: Departures and destinations* (pp. 191-206). Wellington: Victoria University Press.

Boulton, A., Gifford, H., Kauika, A., & Parata, K. (2011). Māori health promotion: Challenges for best practice. *AlterNative 7*(1), 26-40.

Clark, T. C., Crengle, S., Sheridan, J., Rowe, D., & Robinson, E. (2013). Factors associated with consistent contraception use among Māori secondary school students in New Zealand. *Journal of Paediatrics and Child Health, 50*(4), 258-265. DOI: 10.1111/jpc.12450

Copland, R., Denny, S., Robinson, E., Crengle, S., Ameratunga, S., & Dixon, R. (2011). Self-reported pregnancy and access to primary health care among sexually experienced New Zealand high school students. *Journal of Adolescent Health, 49*(5), 518-524.

Crengle, S., Clark, T. C., Robinson, E., Bullen, P., Dyson, B., Denny, S., Fleming, T., Fortune, S., Peiris-John, R., Utter, J., Rossen, F., Sheridan, J., Teevale, T., & The Adolescent Health Research Group. (2013). *The health and wellbeing of Māori New Zealand secondary school students in 2012. Te Ara Whakapiki Taitamariki: Youth'12*. Auckland: The University of Auckland.

Durie, M. (2004). *An Indigenous model of health promotion*. Paper presented at the 18th World Conference on Health Promotion and Health Education, Melbourne, Australia on April 27, 2004.

Durie, M. (1999). Te Pae Mahutonga: A model for Māori health promotion. *Health Promotion Forum of New Zealand Newsletter*, *49*, 2-5.

Durie, M. (1998). W*haiora: Maori health development*. Auckland, Oxford University Press.

Durie, M. (1984). A Maori perspective of health. *Social Science & Medicine, 20*(5), 483-486.

Education Review Office. (2007). *The teaching of sexuality education in years 7 to 13: June 2007*. Wellington: Author

Families Commission. (2013). *Effectiveness of relationship education programmes in schools for years 7-13.* Wellington: Author.

Fenton, M. (2012). *'We have to know what is happening!': Student experiences of a year 10 sexuality education programme* (Master's thesis, University of Canterbury, Christchurch, New Zealand).

Fenton, M., & Coates, A. (2008). *Sexuality education: Best practice literature review and critical appraisal. Report to the Ministry of Health*. Christchurch: Learning Matters Ltd.

Gabel, K. A. L. (2013). *Poipoia te tamaiti ki te ūkaipō* (Doctoral thesis, University of Waikato, Hamilton, New Zealand).

Gallagher, T. (2015). Tikanga Māori: Pre-1840. *Te Kāhui Kura Māori, 0*(1).

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

Harwood, M. (2010). Review of Morgan & Haar (2009), General practice funding to improve provision of adolescent primary sexual health care in New Zealand: Results from an observational intervention. *Māori Health Review, 25,*3. Available from http://www.maorihealthreview.co.nz/

Health Promotion Forum of New Zealand- Runanga Whakapiki Ake i te Hauora o Aotearoa, (2002). *TUHA-NZ A Treaty Understanding of Hauora in Aotearoa New Zealand.* Auckland: Author.

Hutchings, J., & Aspin, C. (2007). *Sexuality & the stories of Indigenous people.* Wellington: Huia Publishers.

Institute of Environmental Science and Research. (2014). *Sexually transmitted infections in New Zealand. Annual surveillance report 2013*. Porirua, New Zealand: Author.

Jones, R. (2000). Traditional Māori healing. *Pacific Health Dialog*, 7(1), 107-109.

Karetu, T. (1995). *The influence of te reo and tikanga on people's perceptions of sexuality.* Paper presented at the Hui Whai Māramatanga, Whai Oranga Mate Ketoketo/Ārai Kore, Papakura Marae, Tamaki-Makau-Rau, 22 March 1995.

King, L. (2014). *'Why don't young men between the ages of 15 and 25 years use the free sexual health services in Huntly?' Evaluation report.* Hamilton: Population Health, Waikato District Health Board.

McClintock, K., Moeke-Maxwell, T., & Mellsop, G. (2011). Appropriate Child and Adolescent Mental Health Services (CAMHS): Māori caregiver's perspectives. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 9*(2), 387-398.

McClintock, K., Mellsop, G., Moeke-Maxwell, T., & Merry, S. (2010). Pōwhiri process in mental health research. *International Journal of Social Psychiatry, 58*(1), 96-7.

McIntosh, T. (2005). Māori identities: Fixed, forced and fluid. In J. Liu, T. McCreanor, T. McIntosh, and T. Teaiwa (Eds.), *New Zealand identities: Departures and destinations* (pp. 38-51). Wellington, New Zealand: Victoria University Press.

Majumdar, D. (2006). Collaboration among government agencies with special reference to New Zealand: A literature review. S*ocial Policy Journal of New Zealand, 183.*

Martin, H. (2002). *TUHA-NZ: A Treaty understanding of hauora in Aotearoa New Zealand.* Auckland: Health Promotion Forum of New Zealand. Retrieved 6 June 2015 from http://www.hauora.co.nz/resources/Tuhanzpdf.pdf

Mark, G., & Lyons, A. (2010). Māori healers views on wellbeing: The importance of mind, body, spirit, family and land. *Social Science & Medicine, 70 (2010),* 1756-1764.

Mauri Ora Associates. (2006). *Best health outcomes for Maori: Practice implications*. Wellington: Medical Council of New Zealand

Mead, H. M. (2003). *Tikanga Māori: Living by Māori values*. Wellington: Huia Publishers.

Mikaere, A. (1995). *The balance destroyed: The consequences for Maori women of the colonisation of tikanga Maori* (Master's thesis, University of Waikato, Hamilton, New Zealand).

Ministry of Health. (2014). *Neighbourhood deprivation (All ages)*. Wellington: Author. Available from http://www.health.govt.nz/

Ministry of Health. (2010). *Tatau kahukura: Māori health chartbook*. Wellington: Author.

Ministry of Health. (2008). *Chlamydia management guidelines.* Wellington: Author.

Moewaka Barnes, H. (2000). Kaupapa Maori: Explaining the ordinary. *Pacific Health Dialog, 7*, 13-17.

Moewaka Barnes, H., Moewaka Barnes, A., Baxter, J., Crengle, S., Pihama, L., Ratima, M., & Robson, B. (2013). *Hapū Ora: Wellbeing in the early stages of life.* Auckland: Whāriki Research Group, SHORE and Whāriki Research Centre, Massey University.

Moorfield, J. (2011). *Te Aka Māori-English, English-Māori dictionary and index*. Otago: Longman/Pearson Education New Zealand.

Morgan, J. M. (2013). *Epidemiology, screening and management of Chlamydia Trachomatis infection in New Zealand* (Doctoral thesis, University of Auckland, Auckland, New Zealand

Morgan, J. M. & Haar, J. (2008). 'Who goes to a sexual health clinic? Gender differences in service utilisation'. *New Zealand Medical Journal, 121*(1287), 44-49.

Murphy, Ng. (2013). *Te awa atua: Menstruation in the pre-colonial Māori world.* Ngāruawāhia: He Puna Manawa Ltd.

National Health Committee. (2002). *Improving Maori health policy*. Wellington: Author.

National Institute of Demographic and Economic Analysis (NIDEA). (2015). *Current trends for teenage births in New Zealand*. Hamilton: Author.

Nepe, T. (1991). *E hao nei e tenei reanga te toi huarewa tupuna: Kaupapa Maori, an educational intervention system* (Master's thesis, University of Auckland, Auckland, New Zealand).

Nikora, L. W., Tamatea, A., Fairbrother, V., & Te Awekotuku, N. (2001). *Te Ahurei a Rangatahi sexual health programme: An evaluation*. Hamilton: Maori & Psychology Research Unit, University of Waikato.

Nikora, L. W., & Te Awekotuku, Ng. (2013). *Moehewa: Death, lifestyle and sexuality in the Maori world*. Paper presented at the 10th Global Conference: Making Sense of Dying and Death, Athens, Greece, 7 - 9 November, 2013. Available from http://researchcommons.waikato.ac.nz/handle/10289/8312

Northland District Health Board (2009). Te Tai Tokerau: Strategic Public Health Plan 2008 - 2011. Whangārei: Author. Retrieved from http://www.northlanddhb.org.nz/Portals/0/Communications/Publications/public%20health%20plan%20final%20_03%20feb%202009_.pdf

Pere, R. (1984). *Te oranga o te whanau: The health of the family*. Hui Whakaoranga. Hoani Waititi Marae, Department of Health.

Pihama, L. (2001). *Tihei mauri ora: Honouring our voices. Mana Wahine as a Kaupapa Maori theoretical framework* (Doctoral thesis, University of Auckland, Auckland, New Zealand).

Rangihau, J. (1992). Being Maori. In M. King (ed.), *Te ao hurihuri: Aspects of Maoritanga* (pp. 183-190.) Auckland: Reed Publishing.

Ratima, M. (2010). *Māori health promotion: A comprehensive and strategic consideration*. Auckland: Health Promotion Forum of New Zealand.

Ratima, M. (2001). *Kia uruuru mai a hauora: Being healthy, being Maori: Conceptualising Maori health promotion* (Doctoral thesis, Massey University, Palmerston North, New Zealand).

Robson, B. (2004). *Economic determinants of Māori health and disparities: A review for Te Rōpū Tohutohu i te Hauora Tūmatanui (Public Health Advisory Committee of the National Health Committee)*. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare, University of Otago.

Robson, B., Harris, R. (Eds). (2007). *Hauora: Māori Standards of Health IV. A study of the years 2000-2005.* Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare.

Rochford, T. (1997). Successful Māori Public Health Initiatives in Aotearoa/New Zealand. *Promotion & Education, 4*(19). DOI: 10.1177/102538239700400311

Rochford, T. (2004). Whare Tapawhā: A Māori model of a unified theory of health. *Journal of Primary Prevention*, *25*(1), 41-57.

Rose, S., Bromhead, C., Lawton, B. A., Zhang, J., Stanley, J., & Baker, M. J. (2012). Access to chlamydia testing needed for high-risk groups: patterns of testing and detection in an urban area of New Zealand. *Australian and New Zealand Journal of Public Health, 36*(4), 343-50.

Sherwood, J. (2006). *Chlamydia screening in New Zealand: Report for the National Screening Unit July 2006.* Wellington: Ministry of Health.

Signal, L., Egan, R., & Cook, L. (2009). *Reviews of health promotion practice in Aotearoa New Zealand 2007-2008.* Auckland: Health Promotion Forum of New Zealand.

Simmonds, N. B. (2014). *Tū te turuturu nō Hine-te-iwaiwa: Mana wahine geographies of birth in Aotearoa New Zealand* (Doctoral thesis, University of Waikato, Hamilton, New Zealand).

Smith, L.T. (1999) *Decolonising methodologies: Research and Indigenous peoples.* New York: Zed Books & Dunedin: Otago University Press.

Statistics New Zealand. (2014a). *Ka maro te aho tapu, ka tau te korowai: Te reo Māori findings from Te Kupenga 2013*. Wellington: Author.

Statistics New Zealand. (2014b). *Te Kupenga 2013*. Wellington: Author.

Statistics New Zealand. (2013a). *2013 Census QuickStats about national highlights.* Retrieved September 2015 from http://www.stats.govt.nz/

Statistics New Zealand. (2013b). *2013 Census QuickStats about Māori*. Retrieved September 2015 from http://www.stats.govt.nz/

Statistics New Zealand. (2011). *Demographic trends 2011*. Retrieved September 2015 from http://www.stats.govt.nz/

Statistics NZ (n.d.). *New Zealand: An Urban/Rural Profile*. Retrieved September 2015 from http://www.stats.govt.nz/

Strobel, N. A., & Ward, J. (2012). *Closing the Gap Clearinghouse: Education program for Indigenous Australians about Sexually Transmitted Infections and Blood Borne Viruses.* Resource sheet No.14 for the Closing the Gaps Clearinghouse. Canberra, ACT: Australian Institute of Health and Welfare. Available from http://www.aihw.gov.au/

Suaalii-Sauni, T., Wheeler, A., Saafi, E., Robinson, G., Agnew, F., Warren, H., Erick, M., Hingano, T. (2009) Exploration of Pacific perceptions of Pacific models of mental health service delivery in NZ. *Pacific Health Dialog, 15*(1), 18-27.

Te Puni Kōkiri. (n.d.). *Aotearoa - Iwi and rohe profiles*. Available from http://tpk.idnz.co.nz/

Terry, G., Braun, V., Farvid, P. (2012). Structural impediments to sexual health in New Zealand: Key informant perspectives. *Sexual Research and Social Policy*, *9*, 317-326.

Waiti, J., & Green, J. A. (2014). *Planning a national STI website that appeals to young Māori*. A report for the Sexually Transmitted Infections Education Foundation. Available from http://tpt.org.nz

World Health Organisation. (1986). *Ottawa Charter for Health Promotion*. Presented at the First International Conference on Health Promotion (1986). Available from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/