Māori Women Talk about Accessing Health Care

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Whakarāpopoto Kōrero

He kaupapa rangahau Māori tēnēi e whakaatu ana i ngā whakaaro o ēnei wāhine Māori mō ngā momo hauora, me te āhua i kite, i rongo ai ēnei wāhine Māori ki ngā whakahaere hauora whānui, me tā te Māori whakahaere hauora. Ko ngā wāhine Māori i utiuia nō ngā tāone, nō ngā kaupapa hauora rātonga marae, he mea ui rātau ki roto i ngā momo hui e titiro ana i ngā momo hauora whakahaere o mua, me o rātua whakarero mō ngā momo hauora o rātānei. Teka mā rau katoa ngā momo pātai i whakaritea, e rua o aua pātai āhanga ki te taha hauora manaaki ki te whakahaunui hauora. Rua teka mā wāhine Māori i tātaritia ā rātua kōrero mō ēnei rangahau. I roto i ngā whakahauntanga rangahau he tika kia āhie te hunga i rangahauia ki te whakaputia i ō rātāu ake whakaaro, me te ako mai i etahi atu mea: kia mārama at ngā kōrero, kia āhanga aua kōrero kia āhurea Māori, kia tautokoia rātāu i roto i ā rātua kaupapa rapu hauora mō rātāu. Ko te take i kōrero ai te hunga i ūia kia āhie atu ki ngā kaupapa hauora e whakahaereia ana i runga i te marae nō te mea ko te taha ita, me te whiwhi waka he i mua atu ki te wāhi hauora, me te noho tahi. Hāunge ēnei whakahaere ko te āhua e pā ana ki te wāhine Māori me o rātua whānau kei roto tonu i te pōhara e noho ana. Ki te kore e āta tirohia te wāhauintanga o ēnei raruraru ka uana rawa mā ngā wāhine Māori ki te manao atu ki ngā momo hauora mā rātua me ō rātua whānau.

Abstract

A qualitative Kaupapa Māori research project investigated how Māori talk about health, Māori health and their experiences of interacting with both mainstream and Māori providers of healthcare. Participants, recruited from urban, marae-based healthcare services, were involved in semi-structured interviews about Māori health, western and traditional healthcare practices, and their personal experiences of health care. Two of the twelve themes arising out of participants' talk related to health care and health promotion. In this paper these themes are examined within the talk of the 20 Māori women involved in the study. In the health promotion theme participants discussed the need for Māori women to be able to talk with and learn from others; to receive information that is understandable and culturally relevant; and to be supported in their health care decisions. The reasons given by participants for Māori women accessing marae-based health services were both functional (cost, provision of transport) and cultural (whanaungatanga). While the kaupapa of the marae could encompass non-Māori health practitioners, the importance of Māori practitioners was stressed. Underlying these aspects, however, is the day-to-day reality of many Māori women and whānau who live in poverty. Unless this broader, societal issue is addressed a major barrier to Māori women accessing health and well-being for themselves and their whānau will remain.

He Wahine, He Whenua - E Ora ai te Iwi: By Women and Land, People are Sustained

Over the past 10-15 years a large number of reports have documented the long running crisis in Māori health (Howden-Chapman & Tobias, 2000; Pōmare, Keefe-Ormsby, Ormsby, Pearce, Reid, Robson & Watene-Hayden, 1995; Public Health Commission, 1995; Royal Commission on Social Policy, 1988; Te Punī Kōkiri, 2000). The focus of these reports has been on Māori/non-Māori inequalities in health outcomes, with some reports taking this commentary further to the level of gender and ethnicity analysis of mortality and morbidity statistics. This gender analysis culminated in 2001 with the Ministry of Women’s Affairs’ (MWA) cross-sector report looking at the impact of inequalities on Māori women (Ministry of Women’s Affairs, 2001).

The MWA report examined health disparities across 20 indicators ranging from life expectancy at birth to mortality rates from suicide and cervical cancer. Perhaps one of the clearest findings in the report is that Māori women are not accessing health care to the extent that their morbidity suggests they should. For example, Māori women are at higher risk than non-Māori women of coronary heart disease and yet receive surgery at approximately half the rate of their non-Māori counterparts. This suggests that there are substantial barriers to Māori women accessing the care that they need to stay well.

Barriers to Health Care

Barriers to health care for Māori have been discussed at a number of levels. Crenge (2000) proposed five types
of barriers to Māori accessing primary health care: financial, geographic (including transport), institutional, knowledge, and cultural inappropriateness. Cost, distance, culturally inappropriate services and lack of knowledge about services were also the main barriers to accessing health services for a third of the respondents in a 1993 survey of Māori households in Palmerston North (Ratima, Ratima, Durie & Potaka, 1993).

Ratima, Ratima, Durie & Potaka (1993) also noted a high level of support among respondents for the establishment of a Māori health service. Their survey demonstrated that whānau were suffering from mostly preventable and/or controllable health conditions. In response the researchers suggested both the removal of barriers for Māori accessing existing health services as well as the establishment of Māori services.

In terms of financial barriers, the over-representation of Māori in the lower socio-economic strata of New Zealand society is linked to both poor health outcomes and increased need (Baxter, 2002). In addition the cost of health services, including physically getting to the service, is also a concern for many Māori (Cram, Smith & Johnstone, 2003). However, even if a service is both available and affordable, people may not be willing to use it if it is not culturally appropriate (Durie, 2001). Durie (2001) also argues that cultural appropriateness will impact on how successful treatment and care are.

There is also some evidence that even when Māori access the health system the treatment they receive within that system is different from non-Māori (e.g., Baxter, 2002). This last point was brought to the fore by Camara Jones (1999) in her discussion of the impact of institutional racism on Māori health and reiterated within the current Māori Health Strategy, He Korowai Oranga. This strategy states that “whānau are not only over-represented in the more deprived groups, but also appear to experience further inequalities over and above those experienced in the same socio-economic group” (Ministry of Health, 2002:19).

Māori Women

Barriers specific to the delivery of health services to Māori women, when discussed within health literature, are often concerned solely with women's genital area. The reasons for this focus in the area of cervical screening were succinctly summed up during the Cartwright Inquiry:

Our cultural mores of modesty are not understood by, or even recognised by most health professionals and especially doctors... The cultural inhibitions on modesty and what is or isn’t proper exposure is ingrained into most Māori girls at an early age.

Exposure of the pubic area is forbidden and proper behaviour and practice during menstruation especially is taught at the onset of menses. (Cartwright, 1988:115)

This view was reflected in the interviews held with Māori women during an evaluation of a cervical screening project in Nelson in 1990 (Lynch & Kanuku, 1990). One third of those women who had had a cervical smear said that it was an embarrassing experience, mainly because of the person who did the smear rather than the procedure itself. The women’s feedback was that they would have preferred a service run by Māori women. The Māori women interviewed for a similar evaluation in the Bay of Plenty agreed that being able to go to a Māori woman for a cervical smear would encourage Māori women to have smears, especially older women (Huygens, 1993).

The impact of colonisation on the passing of women’s knowledge from one generation to the next is another potential barrier to healthcare (Cram & Pitama, 1998). While cultural modesty is a barrier to engaging with non-Māori medical practitioners, a lack of cultural knowledge can leave women without a language to express this modesty, including notions of what is culturally appropriate for them. In addition the disruption of knowledge transfer has been linked to health inequalities. For example Gosden (1992:6), in writing about the experiences of Aborigine women, argues that:

In the past, matters concerning pregnancy and childbirth were part of 'women's business,' and information on these matters was passed on from older to younger women. The dislocation of Aboriginal traditional culture has meant a break with this pattern of communicating knowledge of health... but has produced no satisfactory substitute, as is illustrated by the statistics.

The Gisborne Inquiry highlighted the institutional barriers to Māori women receiving adequate care even if they engaged with the health system for cervical smears. In her evidence to the Inquiry Tracey Tangihare, the Chief Executive Officer of Te Rūnanga o Tūranganui a Kiwa, stated unequivocally that the:

inquiry has given an example of what we see as systemic failure by Tairawhiti Healthcare Limited and the Ministry of Health to provide for the health needs of our Māori women. The issue from our perspective seems to be one of a lack of appropriate resources and there has been an erosion of quality control systems and a failure of robust monitoring systems that have resulted in pain and suffering for our women, their whānau, hapū and īwi. (Tangihare, 2000:2)
The barriers to health care for Māori women are therefore similar to those for Māori more generally but there is little literature exploring the gendered nature of these barriers. In addition, when barriers for Māori women are discussed the focus is usually on a narrow understanding of the nature of whakamāa. For example, within the Ministry of Health’s 1997 document A Brief Narrative on Māori Women and the National Cervical Screening Programme, whakamāa is defined (in the glossary) as humility, embarrassment. There is little or no discussion of the cultural appropriateness of this humility (Cram et al., 2003). There is therefore a need to increase our understanding of Māori women’s experience of healthcare. Previous research has also demonstrated that within this understanding we are also likely to find clues as to how to facilitate better access (e.g., Ratima et al., 1993).

The Present Study

The focus of the present research was on urban Māori discourses about health, and an overview of the findings from this study has been presented elsewhere (Cram et al., 2003). The study of Māori health discourses was, in part, a larger study of health discourses in which two of our Pakehā colleagues, Tim McCleanor and Ray Nairn (2002), were interviewing urban Pakehā GPs about Māori health. Within the Māori health discourse research a number of Māori women talked about issues related to gaining health knowledge and accessing health care. These two themes are explored here in more depth.

Methodology

The present research was based within Kaupapa Māori theory. Kaupapa Māori is an attempt to retrieve space for Māori voices and perspectives (Smith, 1999). It is also about providing a framework for explaining to non-Māori what we have always been about. In this way, Kaupapa Māori is not a new initiative. Kaupapa Māori also opens up avenues for approaching and critiquing dominant, western worldviews (Pihama, 1993). Thus Kaupapa Māori is about reclaiming the right to be Māori within wider society.

The qualitative, interview method in the present study is compatible with Kaupapa Māori as it allows participants to express their experiences fully and in their own terms (Cram, Keefe, Ormsby & Ormsby, 1997). Our role as researchers was to search for meaning and patterns in people’s experience while allowing for the complexity and contradictions that often exist both between and within participants. The validity of this analytical work can be judged in many different ways and we favour the three characteristics coined by Lee (2003) in her theorising of the purakaunui method; that is, the work should be engaging, authentic and thought-provoking. These criteria are addressed in the conclusion.

Participants

Open-ended interviews were conducted with 20 urban Māori women (aged 17 to 75 years). A diversity of women participated, accessed through health programmes offered at two urban marae. Marae-based health programmes were selected as a starting point as it was assumed (and found) that Māori using these programmes would have experienced something of both western and Māori health practices. In this way, we would be able to talk to people about the similarities and differences between mainstream and Māori health services.

Interviews

Open-ended interviews lasting between 30 to 90 minutes were conducted with the women. The interviews were loosely structured to allow the participants to be in the driver’s seat regarding the direction the interviews took, areas that were open to discussion, and the length of the interviews. The topics covered in the interviews included:

- what is Māori health?
- differences between Māori health and the health of the rest of the nation;
- personal experiences with general practitioners and other healthcare providers;
- experiences of family and friends; and
- traditional Māori health practices.

The interviews were audiotaped and transcribed verbatim, by a skilled transcriber. The transcription was then rigorously checked against the audiotape and the informant given a suitable pseudonym. The transcripts have not been edited for readability as this would obscure the way people talked. Repetitions, grammatical errors, etc., therefore remain. Punctuation is also arbitrary but has been placed mainly for readability while retaining meaning.

The transcripts were then read and reread by the researchers and emerging themes were discussed and debated. The development of the themes was also guided by our knowledge and reading in the area of Māori health. Participant feedback was then sought on a preliminary reporting of the results.
Findings & Discussion

Two intertwined approaches to promoting health and well-being arose from the analysis of the interviews and are presented here. First, we present participants’ discussion about how health promotion and education can be made more accessible to Māori women. Second, participants talk about the delivery of Māori health care on urban marae. While this presentation is focussed around the talk of particular participants the issues raised are thematic in that they were raised by many, if not most, of the participants.

Health Promotion

A health promotion programme may lead to behavioural change or a visit to a doctor to have a test. From our discussions with urban Māori women we have pieced together a framework that health promoters might consider when targeting Māori women. It is a framework formed from participants’ talk about how health messages can be accessible to and heard by women. This talk often came out of discussions of the potential barriers to this happening.

Georgina, for example, talked about the difficulties of promoting health when so many other issues, caused in the main by poverty, are impacting on many whānau: I work with them in the homes and like nine times out of ten you’ve got to sort out the practical things within the home and the main issue is really you’ve got to find food. First you’ve got to look at those basic needs first before you can even attempt; I mean if a mother hasn’t got food she’s not gonna listen to you coming in and learn about her smoking or her asthma and things. She’s really not going to be concerned about; she’s more concerned about where she’s going to get the next food parcel or that the powers ready to be disconnected. So it’s like this whole kind of you get stuck back in trying to solve those things and you’ve really got to fix those things up before you’ll even get a mother to come out and to accept that she can come and learn about good health care... For them a cervical smear is way over here you know and the energies that they have that their physical spiritual or whatever energies that they have are being used up just trying to survive. [Georgina]

We are living in a society where 60% of Māori children are part of whānau that struggle to meet their daily financial needs and Māori women are bearing a large part of the burden of this poverty (Hohepa, 1997). In addition, the argument made by the Māori Women’s Welfare League in the first Rapuora study (Murchie, 1984) was that the health of Māori women was central to the health of the whānau. Georgina’s comment above highlights the way in which poverty distracts Māori women from caring for themselves. This, in turn, plays itself out in repercussions for both the woman’s health and the health of her whānau (Benzeval & Webb, 1995; Pōmare et al., 1995).

The acknowledgement of the impact of poverty on Māori women’s health and well-being was accompanied by participants ideas for how, in spite of poverty, Māori women could access health knowledge and health care. One of the participants, Ripeka, demonstrated very ably that educational programmes can change health behaviour. Ripeka had attended many educational programmes and had changed her behaviour as a result. Now, even if she gets a small cut on her finger she says that she will go to see her doctor:

... then you decide to do something so the programme that I attended educated me in that caring for myself... the alcohol and drug treatment centre was [alcohol] and smokefree and of course I went to see the cervical screening programme and I attended that and did what was recommended by them and had a hysterectomy on discovery that there was things weren’t right with me. The smokefree stopped me from smoking (laughs), I chose to stop and the alcohol and drug programme stopped there also. God I’m just about dead aye (laughs). [Ripeka]

A number of other possible programmes were suggested including child rearing, antenatal, nutrition, drug and alcohol, budgeting, and cooking. Counselling was also seen as a need, as was education.

Georgina discussed her experience of health hui and how she thought these could be made more practical and inclusive. This highlighted the need for health promotion and educational initiatives to present information in a way that was understandable and built women’s confidence and esteem. Attendees also need to feel comfortable and not embarrassed or guilty because they see that others in the hui or group are more successful than they are.

To emphasise the points she was making Georgina told of her own experience of attending a smokefree hui and feeling it was a waste of time because the participants were health professionals rather than the people who needed to be educated:

We registered for smokefree. I’m a heavy smoker and I was willing to really try this smokefree programme. Well how it worked out non-smokers were in the programme the smokers were doing the catering. It just defeated the purpose you know and I was, I mean,
I’m a heavy, heavy smoker I know that, I admit that and I was willing just once to really give this a go. Well you know this is this attitude and that’s my attitude and I’m sure a lot of people take that attitude in. Our people say ‘well blow you then I’m not going to stop smoking then’. You know this [hui] was supposed to be for me. It wasn’t for me in the end; it was for people who already have given up smoking or don’t smoke or work in some kind of a health; waste my time. [Georgina]

Georgina also talked about the importance of being able to share personal experiences as part of health education. She had forced herself to have a cervical smear and now she felt able to assure other Māori women that they would be able to do it as well. Such sharing of personal stories was the motivation for a book of Aboriginal women’s stories about pregnancy, childbirth, mothering and community (Gosden, 1992). Thus health promotion can be seen as something that is for indigenous women, by indigenous women. These resources can also inform the training and practice of health professionals, as was the case with the report Ukaipo produced by Te Kura Rata o Otago (n.d.).

In addition to sharing her own experiences, personal support was also important for Georgina in her own health practices and as a result her daughter was going to do a stop smoking programme with her as a support person. For Aroha, talking to rangatahi and giving them support was important:

We are there for them to talk because there are a lot of people who have a lot of problems and they’re there for them to just put energy and love around and that’s what’s been happening. Just understanding themselves, knowing who they are and everything. [Aroha]

Providing support is also about helping in practical ways, for example, with childcare and transport. It may also mean going to where the people are, for example, the Māori Women’s Welfare League cervical screening initiative in shopping centres. Support was also about following up a small hui with a home visit, talking one-to-one, and taking into account the person’s circumstances:

It’s the follow-up week after week after week, say a months follow-up after the programme so that... it just isn’t a flash in the pan, it’s someone really cares for me and they’ve got a support worker there the community health worker could possibly be geared up for that session and support those people for the next month or so. [Norma]

Participants also talked about ways of presenting health information to Māori women. Preference was given to visual presentations and small groups, as Ripeka explains:

I would like to see video visuals. Our people are visual, they love seeing [pictures. They] very seldom want to sit down and read a magazine on their health but visual aids like good visual aids one that you’re gonna push the button and it goes and they can see straight away this is what your heart does and this is what happens when your heart doesn’t is functioning properly high blood pressure diet. I think you can talk your head and there’s nothing like seeing what happens so good visual aids is something that we have not had and why we scribble on a white board and this is good enough so I think good video aids, visual aids are essential follow up. [Ripeka]

This is similar to findings reported by Keri Ratima and colleagues from Massey University when they examined cervical screening and maternity services for Māori women (Ratima, Ratima, Durie & Potaka, 1994). In addition, these researchers noted the importance of having a range of information options available including Māori specific options.

In summary, participants’ suggestions for promoting health among Māori women were based on acknowledging peoples’ circumstances and needs. For example, health promotion is unlikely to be very successful if women are more concerned about day-to-day difficulties brought about by poverty than they are about their personal health. This is not to say that health promotion should not also be about trying to ease the burden of poverty. Appropriate health promotion was therefore seen as including the opportunity to:

talk with and learn from others, including kuia and koroua;

hear and see information that is understandable and culturally relevant; and

receive support and/or follow-up when accessing health services and/or attempting to change behaviour (e.g. give up smoking).

Marae-based Health Care Delivery

As explained by the draft strategic vision for Omangia te Oma Roa (1997:6), the marae:

has the capacity to nurture and develop each individual, whānau, hapū and iwi;

provides a place for each person;
provides a place to welcome and farewell people from this world to the next; embodies the whare in which an analogy has been made that good health for Māori is dependent upon each wall of the house being strong, of equal strength and interconnected; and provides a place of learning and an environment for constant personal and cultural development.

The marae is often described as the best place to offer accessible and appropriate health care and other services for Māori (e.g., Ratima et al., 1994). Participants talked about meeting people's needs through giving them access to marae health services:

I think they need to have it on the marae, they need to because, for the Māori, because it's really hard to put it across to them you know, but if they get something like this, you see they bring their children and of course there is a car that will go and pick them up. So I think that it's good service, you need the service for them. Just to start them you know, to, it's only a start they need, you only need an opening and encouragement and confidence. [Aroha]

For Aroha (above) this was about providing transport and allowing people to bring their children; for Dionne and Lyn it was about providing people with a place to gather – for mothers to get a break from their children and for whānau to meet:

Everybody seems to collect around here and ah they all seem to be whānau to one another, yeah. So when they come over it's good to see a nanny here and you see them all come in and give them a kiss and things like that before they sit down and have a little matter before they go into the doctor and it's nice when you see all that. [Dionne]

...the kid is crying and the mother looks so sad it. Oh you've just got to feel sorry for them, so yeah you take the baby and you take him for a walk around to stop it crying so the mother can have just a couple of minutes break away from the child. [Lyn]

For some participants the key feature of marae-based health services were that they were provided either free-of-charge or much cheaper than other health services. The importance of providing transportation to the marae health clinic was also discussed:

I believe that there are a lot out there that need support and if support means just picking them up and taking them to the doctor, not a problem, cause some of them might have to taxi and there’s another ten dollars that they don’t need to spend making Pākehā rich that they could possibly use on the medicine or something extra for their child or fruit for their babies that’s ten dollars in their pocket. [Ripeka]

The other side to transporting people to a marae health clinic was the provision of in-home services by health workers who are based at the marae. A health worker visiting someone's home can observe difficulties and get a feel for what is going on with a whānau rather than, perhaps, just addressing the problem that one person might present with at a clinic. Dionne, a health worker at a marae clinic, explained this:

Like they will come here but we'll also do a visit at their home too, It's no use just talking in the office: you don't know what's going on in their house and if you don't go down there and have a look for yourself then you won't know what the problem is. There might be other areas that they need also need help with and you can come back here and maybe refer them to health or refer them to family support where they can get their other needs met as well... just sit there and have a talk with them and explain to them ah and they'll come with their problems or their needs. [Dionne]

Georgina also stressed the importance of supporting people in their homes because they may be ashamed, "...because other people are hearing their hang-ups or their inabilitys to cope you know and our people are like that. I'm afraid they don't like their inabilitys broadcast publicly [Georgina]."

The health practitioners working at marae are not necessarily Māori. However the way they practice and the atmosphere at the marae might be quite different from what people have experienced elsewhere. Georgina talked about the Plunket service offered from the marae, saying that the atmosphere was more relaxed and the practitioners are more accessible. Aroha also talked about how the marae's Pākehā doctor (doc doc) had created a rapport with patients so that they felt comfortable and safe, "I go to the marae now, the doctor's right there now. She's excellent and I find I can talk to her [Aroha]."

Other participants, such as Grace, talked about the importance of having Māori providers available for Māori patients. Māori providers were seen to provide that extra connection based in shared cultural understandings:

The antenatal kaupapa here at the marae: the whānau are invited to come along with their daughter so that they can have that support during the discussions in
relation to their pregnancy. This is delivered by the skills of the midwife who has been trained and is up to date in that knowledge but they are Māori midwives because their wairua comes through and enlarges a lot more of the discussions that if they went to an antenatal class which is totally clinical which is just surrounding that period of pregnancy. We have kaumatua kuia there that they have the freedom to korero to the kaumatua kuia any time or any stages that they’re there at the marae. [Grace]

In summary, marae-based health services are often accessible to Māori women for functional reasons (such as transport being provided to the marae and the health service being cheap if not free), and cultural reasons (such as children being welcome and that the marae is a meeting place for people). Accessibility is also about providing good clinical service. Sometimes a non-Māori health practitioner who has been trained to be Māori-friendly can provide this. However participants stressed the importance of also having Māori health practitioners, working alongside kuia and koroua. When the marae is not accessible because of other things going on in people’s lives (e.g., poverty), a marae-based service can provide a link for people through the delivery of home-based services.

Conclusion

Māori women recognise the value of being healthy (see also, North Health, 1996). The premature deaths of Māori women, at whatever age, means the loss of kuia and this has a detrimental effect upon Māori society. It is also a breach of the Treaty of Waitangi (Reid, 1999). Health care solutions are needed and the best people to inform these solutions are Māori women themselves.

Although the numbers of women who were interviewed for the present study was small we can apply our three criteria to these findings. The authenticity of findings has three components: the analysis was conducted by Māori women within a Kaupapa Māori framework; the findings are compatible with and extend previous research findings; and the preliminary report of the findings was acceptable to the participants. The participants also found this preliminary report both engaging and thought-provoking. The inclusion of quotations from participant’s talk within this report is a second element of engagement. We are not asking readers to agree or disagree with our analysis but rather to reflect on what the participants have said and the context in which we have placed their talk.

Our discussions with urban Māori women about health promotion and marae-based health care delivery highlighted the need for culturally appropriate, safe and accessible health care delivery mechanisms that acknowledge the day-to-day realities of urban Māori women. The delivery of health promotion and health care from a marae base may well be more accessible and appropriate for Māori women because it offers functional, cultural and clinical ways of addressing health issues. In addition, Lawson-Te Aho (1998) argues that the marae can be both a physical location as well as a metaphorical reality. In other words, the kawa and tikanga of the marae travels with health workers and exists within Māori and iwi health providers (including Māori groups who are part of mainstream health providers) that may not be based at a physical, marae location (Cram & Pipi, 2000).

The delivery of good health to Māori women should not, however, be the sole responsibility of Māori and iwi health workers and providers. One of the main barriers to health care for Māori women is poverty and this needs to be addressed by the wider health system as well by society as a whole (Ministry of Health, 2002; Pomare et al., 1995). It is only then that Māori women will be able to fully access health and well-being for themselves and their whānau.

References


Te Kura Rata o Otago (n.d.). Ukaipo (Mother): A Resource for Undergraduate Medical Students.


Endnotes

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