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September 1998
Oranga Niho: A review of Māori oral health service provision utilising a kaupapa Māori methodology

A thesis submitted for the degree of Doctor of Philosophy at the University of Otago, Dunedin, New Zealand

John Broughton  BSc (Massey) BDS (Otago)
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Abstract

Title: *Oranga Niho: A review of Māori oral health service provision utilising a kaupapa Māori methodology*

The goal of this study was to review Māori oral health services utilising a *kaupapa* Māori framework.

The aims of the study were to identify the issues in the development, implementation and operation of Māori dental health services within each of the three types of Māori health providers (mainstream, *iwi*-based, partnership). The three Māori oral health services are:

(i) Te Whare Kaitiaki, University of Otago Dental School, Dunedin.

(ii) Te Ātiawa Dental Service, New Plymouth.

(iii) Tipu Ora Dental Service, in partnership with the School Dental Service, Lakeland Health, Rotorua.

Method:

A literature review of *kaupapa* Māori research was undertaken to provide the Māori framework under which this study was conducted. The *kaupapa* Māori methodology utilised the following criteria:

(i) *Rangatiratanga*: The assertion of Māori leadership;

(ii) *Whakakotahitanga*: A holistic approach incorporating *Te Whare Tapa Whā*;

(iii) *Whakapapa*: The origins and development of *oranga niho*;

(iv) *Whakawhanuitanga*: Recognising and catering for the diverse needs of Māori;

(v) *Whanaungatanga*: Culturally appropriate forms of relationship management;

(vi) *Māramatanga*: Raising Māori awareness, health promotion and education; and
(vi) *Whakapakiri*: Recognising the need to build capacity of Māori health providers.

Ethical approval was granted by the Otago, Bay of Plenty and Taranaki Ethics Committees to undertake interviews and focus groups with Māori oral health providers in Dunedin, Rotorua and New Plymouth. Information was also sought from advisors and policy analysts within the Ministry of Health. A valuable source of information was *hui kōrero* (speeches and/or discussion at Māori conferences). An extensive literature was undertaken including an historical search of material from private archives and the now defunct Māori Health Commission.

**Results:**

An appropriate *kaupapa Māori* methodology was developed which provided a Māori framework to collate, describe, organise and present the information on Māori oral health.

In *te aotawhito* (the pre-European world of the Māori) there was very little if any dental decay. In *te ao hou* (the contemporary world of the Māori) Māori do not enjoy the same oral health status as non-Māori across all age groups. The reasons for this health disparity are multifactorial but include the social determinants of health, lifestyle factors and the under-utilisation of health services. In order to address the disparities in Māori oral health, Māori providers have been very eager to establish *kaupapa Māori* oral health services. The barriers to the development, implementation, and operation of a *kaupapa Māori* oral health service are many and varied and include access to funding, and racism. Māori health providers have overcome the barriers through two strategies: firstly, the establishment of relationships within both the health sector and the Māori community; and secondly, through their passion and commitment to *oranga niho mō te iwi Māori* (oral health for all Māori). The outcome
of this review will contribute to Māori health gain through the recognition of appropriate models and strategies which can be utilised for the future advancement of Māori oral health services, and hence to an improvement in Māori oral health status.

Conclusion:

This review of Māori oral health services has found that there are oral health disparities between Māori and non-Māori New Zealanders. In an effort to overcome these disparities Māori have sought to provide kaupapa Māori oral health services. Whilst there is a diversity in the provision of Māori oral health services, kaupapa Māori services have been developed that are appropriate, effective, accessible and affordable. They must have the opportunity to flourish.
Dedicated to

Te Ao Mārama the New Zealand Māori Dental Association

for their commitment:

*Hei oranga niho mō te īwi Māori.*
Acknowledgements

He whakatauākī mō te tuhinga whakapae nei: He rei ngā niho, he parāoa ngā kauae
A proverbial saying for this thesis is: A whale's tooth in a whale's jaw.
This is a metaphor meaning that one must have the right qualifications for great enterprises.

I would like to pay tribute to those people and organizations who were so supportive of me in undertaking this thesis: Mrs Inez Kingi and Mr Pihopa Kingi, *kuia* and *kaumātua* of Tipu Ora Trust, Ōhinemutu, Rotorua and president and *kaumātua* of Te Ao Mārama, the New Zealand Māori Dental Association; Dr Tony Ruakere of Te Ātiawa Medical Centre, New Plymouth; Dr Chris Taylor, dentist of Te Ātiawa Dental Centre, New Plymouth; Dr Eithne MacFadyen of the University of Otago Dental School; Mr Karaka Roberts, *kaumātua* of Dunedin; The Mana Whenua Health Working Party, Dunedin; the Ministry of Health, Wellington; and my two supervisors, Associate Professor W Murray Thomson and Associate Professor Rob McGee. I would also like to acknowledge those people within the dental health sector, both Māori and Pākehā, who shared their thoughts and expertise with me; their *kōrero* (stories) enriched the Māori dimension of this study. *Ka nui te mihi aroha ki a koutou katoa.*
Chapter 1  
*Te Kōrero Tuatahi*  
(Introduction)

1.1 Background

Māori are unique to New Zealand. The origins of Māori lie in the mist of time having crossed Te Moana-Nui-a-Kiwa (the Great Ocean of Kiwa) in waka or canoe from the far distant Hawaiki. The migration to New Zealand occurred over a five hundred year period from the early moa hunters of circa 800AD to circa 1300AD. Māori established their way of life and social system based on whānau (family), hapū (subtribe) and iwi (tribe) which traced their whakapapa (descent lines) back to waka. The first European contact was in 1642 with the arrival of Able Tasman, a Dutch explorer who left the name, Staten Land on the new found continent. Captain Cook arrived in 1769 and during three voyages mapped the coastline of the country and wrote extensively of the native inhabitants. European contact with the native New Zealanders or tangata whenua involved a slow but steady stream of European visitors coming to New Zealand. These were mainly whalers, sealers, traders, and missionaries from the early 1800’s who established close working relationships with Māori. By the mid-1830’s both Māori and the British wished to formalise this relationship. This was achieved through the Treaty of Waitangi which saw New Zealand’s sovereignty pass from Māori to the British Crown in return for the promise of tino rangatiratanga (Māori self-determination) and Māori having the same rights and privileges as British subjects. Besides the settlers demand for land there was also a demand for teeth. In Europe at this time before the advent of plastics and porcelain teeth, dental prostheses were set with real teeth. Brooking (1980) gives an account of a trade that developed in the 1830’s in New Zealand with some Europeans requesting
to purchase the teeth of the local aboriginal inhabitants of New Zealand, so that these could be taken back to England for the manufacture of dentures. Two dental surgeons of London, Wilkes and Jones, were criticised for bribing healthy Māori to allow them to extract their teeth. These teeth were exported to England and used to make dentures.

The latter half of the 19th Century saw massive immigration to New Zealand from Britain. Whilst the coming of the European to New Zealand had a huge impact upon Māori, the effects of colonisation did not destroy Māori or their way of life. Māori did adapt to the new culture imposed upon them but at great cost. The initial impact was the devastating effect upon Māori health and well being. During the latter part of the Victorian era Māori were believed to be a dying race with the population having fallen from 150,000 in 1835 to 43,113 at the 1896 Census (Department of Statistics 1990). Māori were subject to political domination, cultural alienation, and economic exploitation resulting in demoralisation and despair. However, despite that, Māori have not only survived but have seen a remarkable increase in population with over half a million New Zealanders identifying as Māori at the 2001 Census. Throughout the 230 year period since Captain Cook, Māori have adapted to the changing social environment and have had to meet the challenges and the demands, the racism, the injustices, and the inequalities. Despite the negativity, Māori have survived as a people, albeit a diverse people today. Māori society including their beliefs, attitudes, values, cultural practices are part of what makes New Zealand unique. It is therefore fitting that this thesis on Māori oral health be undertaken by Māori with a uniquely Māori approach, a kaupapa Māori research approach.
1.2 *Te Timatanga* (The Beginning)

In order to document the origins of teeth and oral health from within the Māori world view it is necessary to go back to Te Aho Matua, the Creation. This was how the Māori of *te ao tawhito* (The pre-European world of the Māori) explained their world at that time. Whilst the Western scientific view would dismiss this belief system as being mythological and of little or no relevance today, many Māori today holdfast to strong beliefs in the spiritual realm of their origins. This information was imparted to J Broughton in a series of wānanga (learning/teaching session) with kaumātua (elder), Mr Karaka Roberts. Whilst there are many documented versions (Pere 1991, Shires 1997) of this kōrero (story), the discussion presented here is that of this particular kaumātua. It is no less valid. Mr Roberts chose to express the sentiments bilingually in both te reo Māori (Māori language) and in English. The sentiments he expressed in English are not a translation of that presented in Māori but was done deliberately to impart this knowledge in both worlds, Māori and European. Mr Roberts moved freely between the Māori language and the English language. The following account is from Mr Karaka Roberts.

Io was Te Aho Matua, the parentless, who created everything that had life.

Io gave life.

Te Kore was the great void of nothingness.

From this great void of nothingness we came.

The dormancy.

The potential.

The source,

That spanned a billion years,

---

1 Mr Karaka Roberts, personal communication.
Yet knew no time.
That was all and everything,
Yet knew no form.
In the beginning,
In the void of non-being,
Where nothing had been,
Where nothing would be.
From this great Nothingness came the night.

Twelve stages of the night:

Te Pō Nui;
Te Pō Roa;
Te Pō Namunamu;
Te Pō Tē Kitea;
Te Pō Tangotango;
Te Pō Uriuri;
Te Pō Kimihanga;
Te Pō Rapunga;
Te Pō Anuanu;
Te Pō Mātao;
Te Pō Miringa;
Te Pō Whakau ai Te Uio.

Eventually came Te Ata, the Dawn.

Twelve stages of light.

Ka Ao........Ka Ao.

The twelve stages of Night,
And twelve stages of Light,
Are linked to the twelve Heavens.
Te Kawa Tuatahi;
Te Kawa Tuarua;
Te Kawa Tuatoru;
Te Kawa Tuawhā;
Te Kawa Tuarima;
Te Kawa Tuaono;
Te Kawa Tuawhīti;
Te Kawa Tuawaru;
Te Kawa Tuaiwa;
Te Kawa Tekau;
Te Kawa Tekau-Mā-Tahi;
Te Kawa Tekau-Mā-Rua.

Indeed where nothing was the void,
That knew not form,
Or substance,
Found itself coming into being.
It was the birth of opposing forces.
Rangi-nui above,
Papa-tū-ā-nuku below.
So from the vast nothingness of the void,
Was the potential unleashed.
An infinite spiral born of itself.
Io Matua Kore.
A self motivated power that was its own source.

The whakapapa of te tangata (the person) is from atua (supernatural being), Rangi-nui (The Sky Father) and Papa-tū-ā-nuku (The Earth Mother) who begat Tāne-
mahuta, (God of the Forest) who in turn created Hine-ahu-one (The Earth Formed Maid) and hence the human being. Encompassed within te tinana (the body) was te waha (the mouth) and te niho (the teeth).

1.3 Hauora Māori (Māori Health)

Hauora Māori is the health of Māori people. Māori have a view of health based on four cornerstones (Durie 1985): te taha tinana (the physical dimension); te taha hinengaro (the mental dimension), te taha whānau (the family/social dimension) and te taha wairua (the spiritual dimension). This holistic approach to health requires all four aspects to be secure and in place for overall health and well being. These concepts are not unique to Māori; they are universal themes for Indigenous People in particular, throughout the world. The meaning of these four dimensions to Māori is unique and makes up part of a unique Māori world view.

1.4 Health Inequalities

Unfortunately, like Indigenous Peoples around the world, the Māori people of New Zealand do not enjoy the same health status as the majority European population. The poor health status of Māori people has been well documented (Pōmare et al. 1995). The disparities were highlighted in a report (Te Puni Kōkiri, 1998) released by the Minister of Māori Affairs in 1998 which became known as The Gap Report. Socio-economic status is related to health status and Reid et al. (2000) described health disparities based on the NZDep 96 Index Of Deprivation. This showed that “more than half (56%) of Māori live in areas represented by the three most deprived deciles.” The Decades of Disparity report (Ajwani et al. 2003) revealed that whilst the life expectancy for Europeans has increased over the last two decades, this has not
occurred for Māori. A disturbing health disparity exists between Māori and non-Māori New Zealanders which indicates that there are underlying issues within New Zealand society that has brought about the situation that we have today.

1.5 Oranga niho

Oranga niho is Māori oral health (or strictly translating, dental health.) The mouth has important cultural connotations for Māori. Mātauranga Māori or Māori knowledge was passed on to those selected to participate in the Whare Wānanga or House of Learning through an oral transmission of information. Hence te waha (the mouth) was viewed as the entrance way to the body and ngā niho (the teeth) were the guardians standing at the portal. The mouth was therefore an important instrument in Māori oral traditions with te reo (language), karanga (the ceremonial call of the women), whaikōrero (oratory and speech making), and waiata (song) being central to Māori cultural practices. In te ao tawhito (pre-European Māori society) Māori did not suffer unduly from dental caries (Houghton 1980). In fact there was very little if any dental decay as there was no sugar-based foods in the diet. There was, however, periodontal disease and attrition of the occlusal surfaces of the teeth. Māori did suffer from tooth ache which were treated with both spiritual and clinical remedies (Riley 1994). The impact of colonisation and the introduction of sugar in the diet resulted in the marked deterioration of the oral health of Māori.

At the present time Māori do not enjoy the same oral health status as non-Māori New Zealanders. There are a variety of reasons for this situation which are both wide and varied and are still not fully understood despite taking socio-economic factors, lifestyle factors such as diet, and health service provision factors into account. The 1998 Gap Report did not mention dental health status due to the lack of any recent reliable data on adult Māori dental health. The concern was raised in the Ministry of
Health Report, *Well Being of Whānau* (family) (Ministry of Health 1998a) which noted that, “Māori have relatively poor dental health compared to non-Māori.” Broughton (1994) noted that “dentistry has had a very low priority with Māori people. Indeed, for many Māori people, dentistry did not rate at all.” However, over the decade of the 1990’s there was a growing concern among Māori communities about their oral health or lack of it. The Māori response was a slow but gradual development of Māori oral health initiatives. Although, there is now an increasing awareness of *oranga niho* (dental health) within the Māori population (Broughton 1995, Dyall 1997), the current belief is that the disparities in oral health require significant improvement for Māori to reach the Government’s objective for Māori health (Department of Health 1993): “The Crown will seek to improve Māori health status so that in the future Māori will have the same opportunity to enjoy at least the same level of health as non-Māori.”

1.6 Māori Health Providers

Since the health reforms of the National Government of the early 1990’s which introduced the concept of the health funder and the health provider, Māori were for the first time able to access resources for the development and provision of Māori health services. A Māori health provider has been defined (Ministry of Health 2002a) as “an independent Māori health provider whose services are targeted towards Māori, and have a Māori management and governance structure.” In 1992 there were only six Māori health providers which has now grown to 240 Māori health providers with DHB or MOH contracts by 2003. This massive increase in Māori health service provision is due to the assertiveness and determination by Māori to address Māori health concerns.

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2 Personal communication. Mr Rob Cooper, HFA Manager for Maori Health, 1998.
There are essentially three models of Māori health service delivery. Health services may be delivered by providers that are based within mainstream organizations such as a hospital or are part of a national organization such as Plunket. Health services may be delivered by providers that are iwi or community based and are under the governance of a Māori Trust Board or a Māori Community or Urban Trust Board. The other model of health service delivery is a Māori provider that operates in partnership with another health service provider or organization through a mutually agreed contractual arrangement. There are now a diversity of providers with a wide range of services from primary health care, health promotion and education, screening, mental health services, tamariki ora (child health) services, rangatahi (adolescent) health, kaumātua (the elderly) support services and health service and community liaison. The rise in Māori health services have greatly increased the access of Māori to affordable and appropriate health services.

1.7 Māori oral health providers

Over the last decade, Māori have actively been pursuing the development of dental health services that are accessible, affordable, acceptable and appropriate. Since 1990 a very small number of providers have developed a specific range of dental services for Māori within each of the three models of Māori health service provision. These services have developed within their respective communities to attempt to meet the oral health needs of their communities in their own particular way. As such they have had to overcome a wide variety of issues to ensure the delivery of quality dental health services. This thesis aims to investigate the issues surrounding the development, implementation and operation of three models of Māori health service provision, one in mainstream, one that is iwi (tribal) based and one that is in partnership. The Māori oral health services are:
(i) A provider that is based within a mainstream services or organization:
Te Whare Kaitiaki within the School of Dentistry, University of Otago, Dunedin.

(ii) A provider that is iwi or community based:
Te Ātiawa Dental Service, New Plymouth.

(iii) A provider that is in partnership with another service or organization:
Tipu Ora, Tūnohopū Health Centre, Ohinemutu, Rotorua. This Māori provider is in partnership with the School Dental Service, Lakeland Health.

1.8 Kaupapa Māori Research

A kaupapa Māori (Māori philosophical approach) research is essentially research that is undertaken by Māori, about Māori, and for Māori. In undertaking this review of Māori oral health services a kaupapa Māori methodology will be used. This is appropriate as Māori have often felt disadvantaged as assessment tools used to measure outputs, outcomes and effectiveness of Māori initiatives have not always taken account of Māori philosophy, custom or processes. An example is the Education Review Office which has now developed relationships with Māori educational institutions so that external evaluations of kura kaupapa (Māori immersions schools) should be taken in partnership with Māori including the adoption of appropriate protocols and processes (Education Review Office 2000). A review of the literature of kaupapa Māori research was conducted from which a framework was developed for this study. This framework provided a means of organising the information in a structured way that is both meaningful and relevant to Māori. The development of this framework is discussed in Chapter 2.
1.9 *Te Whakamutunga* (The Conclusion)

The unfortunate reality is that there are major oral health disparities between Māori and non-Māori New Zealanders. The reasons for this situation are complex and multifactorial. One strategy to overcome the unmet dental health needs of the Māori population is the development of Māori oral health services. This thesis is a review of Māori oral health service provision by focusing upon three different types of Māori oral health providers. The aim of the review will be the identification of issues surrounding the development, implementation and operation of *kaupapa Māori* oral health services. The outcome will contribute to Māori health gain through the confirmation of appropriate models of Māori oral health service delivery and the consequent improvement in the oral health status of Māori.
Chapter 2

Kaupapa Rangahau Māori
(Māori Research Philosophy)

2.1 Kaupapa Māori Research

2.1.1 Te Kōrero Tuatahi (Introduction)

"Te ao hou" is an expression that refers to "the new world", or contemporary Māori society. In contrast "te ao tawhito" refers to "the old world" of pre-European Māori culture and society. A concept that spans both worlds is "kaupapa". Williams (1971) presents 12 different meanings of the word from "level surface, floor, stage"; "raft"; "groundwork to which feathers were attached in the making of a cloak"; "medium for intercourse with an atua"; "fleet of canoes"; "sticks used in the rite of divination"; "original of a song"; "trail, track"; "gauge for meshes of a net"; "even, in length" and "plan, scheme, proposal". Ryan (1974) translates the word as "rule; basic idea; topic; plan; fleet (of ships); foundation", whilst Ngata (1994) translates the word to mean "subject". Today, Māori often ask, "Hei aha te kaupapa?" (What is the subject/topic?), or may announce, "Te kaupapa o tēnei hui..."(The subject under discussion at this gathering is...), or may state, "Kei te tū ahau ki te tautoko te kaupapa o..." (I stand to support the notion/idea of...). The expression, "kaupapa Māori" has become so frequently used in recent years that it has colloquial meanings of "things Māori", "a Māori approach", or in its broadest sense, "a Māori way of doing things." Bishop (1996) gives meaning to kaupapa Māori when he states:

Smith, G. (a Māori educationalist) describes Kaupapa Māori as 'the philosophy and practice of being and acting Māori'. It assumes the taken for granted social and political, historical, intellectual and cultural legitimacy of
Māori people, in that it is a position where ‘Māori language, culture, knowledge and values are accepted in their own right’.

But Linda Smith (1999) comments that “the concept of kaupapa implies a way of framing and structuring how we think about those ideas and practices”. The critical aspect according to Smith is that Māori forms of knowledge are understood “on their own terms and within the wider framework of Māori values and attitudes, Māori language, and Māori ways of living in the world.” In general, Māori have no problems understanding what “kaupapa Māori” means in any given context. It is essentially, phenomena that are about Māori looked at through Māori eyes.

The use of the expression “kaupapa Māori” has been extended to “kaupapa Māori research” to mean research that is conducted within a Māori cultural context. This has very wide connotations for research. Linda Smith (1998) notes that “a research methodology is a theory and analysis of how research does or should proceed.” When this notion is applied to the concept of “kaupapa Māori research” it is understood to mean a research method that is conducted from a Māori perspective taking into account Māori beliefs, attitudes, values and cultural constructs. Whilst there has been considerable debate among Māori at hui and in the literature (Durie 1998, Health Research Council 2003) as to the definition of kaupapa Māori research, most would support the notion that kaupapa Māori research is “research that is conducted by Māori for Māori about Māori”. Kaupapa Māori research offers a theoretical framework to conduct research that is relevant, meaningful, appropriate and acceptable to Māori. The results or outcomes of that research have reliability, validity, relevance, meaning, is appropriate and acceptable to Māori and most importantly, are beneficial for Māori.

The significance of kaupapa Māori research to Māori is that it now exists in its own right. Some would argue that the discipline of research occurred within te ao tawhito
along lines that were appropriate for Māori at that time. The fact that there is now a label, ‘kaupapa Māori research’, immediately implies that not only is this something new; it did not occur in the pre-European times, but that there are, or have to be, comparisons with Western research. Fortunately, Linda Smith (1999) provides a very clear explanation of the dynamics of kaupapa Māori research:

*Kaupapa Māori* research is a social project; it weaves in and out of Māori cultural beliefs and values, Western ways of knowing, Māori histories and experiences under colonialism, Western forms of education, Māori aspirations and socio-economic needs, and Western economics and global politics.

In undertaking this thesis, the starting point was the development of an appropriate *kaupapa Māori* research framework that would allow the research methodology and analysis to proceed. As a starting point, it was essential to look at the Indigenous Peoples’ position from a global perspective. The involvement of Indigenous populations in health research - either as the researchers or the researched - requires the application of principles that are defined by Indigenous People so that research outcomes will have appropriate meaning and relevance for them.

2.1.2 Indigenous People and Research

The first question that arises, then, is exactly who is or what are Indigenous People? The World Health Organisation (WHO) (2003) view is that there is in fact “no internationally accepted definition of Indigenous Peoples.” There are however, four criteria which the WHO has identified and can be “applied under international law and by United Nations organisations and agencies to distinguish Indigenous Peoples.” These four criteria are:

(i) residence within or attachment to geographically distinct traditional habitats, ancestral territories, and natural resources in these habitats and territories.
(ii) maintenance of cultural and social identities, economic, cultural and political institutions, separate from mainstream or dominant societies and cultures.

(iii) descent from population groups in a given area, most frequently before modern states or territories were created and current borders defined.

(iv) self-identification as being part of a distinct indigenous cultural group, and the display of desire to preserve that cultural identity.

Māori are an Indigenous People as specified by these criteria:

(i) Māori have takiwa or traditional tribal areas that are explicitly demarcated. The whole of New Zealand is divided into tribal areas with tribal boundaries.

(ii) Māori maintain their cultural and social identities through the recognition of waka (ancestral canoe), whakapapa (genealogy) and marae (institution).

(iii) Whakapapa defines both individuals and whānau collectives, hapū and iwi through common ancestral links and associations.

(iv) Over half a million New Zealanders self-identified as Māori at the 2001 Census. The preservation of cultural identity is manifested through such entities as kōhanga reo (Māori pre-school), kura kaupapa (Māori schools), tikanga (custom) and kawa (protocol) of the marae (Māori societal institution), toi Māori (Māori arts) and Māori health providers.

The second question that arises is, where do Indigenous Peoples stand with regard to health research? This question encompasses research that may have either a direct or indirect impact upon specific Indigenous populations. The significance of this question
is that for many centuries Indigenous knowledge, intellectual property and customary artefacts, beliefs and practices have been stolen, misappropriated, destroyed, defiled and condemned by a dominant colonising culture. The WHO view is that "health research involving Indigenous Peoples, whether initiated by the community itself or by a research institute, needs to be organised, designed and carried out in a manner that takes account of cultural differences, is based on mutual respect, and is beneficial and acceptable to both parties." From an Indigenous perspective, it is therefore appropriate for health research to be conducted within a framework that is appropriate for that particular Indigenous population. In this thesis, an appropriate Māori framework is developed for undertaking the specific research project on Māori oral health services.

2.1.3 Māori Knowledge and Time

A widely accepted belief system within Māoridom is "looking back to the future."

A commonly heard phrase is, "E ngā wā o mua..." which is understood to mean, "In days of old..." a reference to the past. This is a misnomer as the word 'mua' means 'in front'. This then gives an indication as to the Māori view of past, present and future. A Māori sees the past in front as it has already happened, he has been there and can therefore "see it". The future however, has not yet occurred; it cannot be seen and therefore lies behind the person.

The significance of looking forward to the past for Māori is the strong belief in whakapapa, tribal histories and the wisdom of ancestors. These aspects of Māori experience of the past are embodied in the philosophical view that, without a past, there is no future. This sentiment is often voiced as "ngā taonga tuku iho o ngā mātua tūpuna" which would translate as "the treasures (knowledge) handed down from ones ancestors". This knowledge is used today for the benefit and well being of future generations. The most widely known expression of this concept is the whakatauākī
(proverbial saying) of Sir Apirana Ngata who wrote in a young Māori high school student’s autograph book in 1949:

\[ E \text{ tipu } e \text{ rea } mō \text{ ngā } ra \text{ ō } tōu \text{ ao; Ko tō } \text{ ringaringa } \text{ ki } ngā \text{ rākau } ā \text{ te Pākehā, hei oranga mō } tō \text{ tinana; Ko tō } \text{ ngākau } \text{ ki } ngā \text{ taonga a } ō \text{ tūpuna Māori, hei tikitiki } mō \text{ tō } \text{ māhunga, Ko tō } \text{ wairua } \text{ ki } tō \text{ Atua, nāna nei ngā } \text{ mea katoa.} \]

Grow up, o tender plant, for the days of your world, your hand to the tools of the Pākehā, for the welfare of your body, Your heart to the treasured possessions of your Māori ancestors, set as a crown for your head, Your spirit to God, the creator of all things.

The sense of time is, therefore, an important consideration in the understanding of Māori knowledge, where it comes from and from whom it comes.

Cunningham (1998) takes this notion of past, present and future to develop a model of past and future knowledge:

From the past, the dimensions include:

(i) Wholism
(ii) Māori social system
(iii) Oral tradition

For the future, the dimensions include:

(i) Social and cultural diversity
(ii) The Treaty of Waitangi
(iii) The responsiveness to Māori and consultation

This model can be applied as a framework for Māori health research as outlined in Table 2.1 and Table 2.2.

\[ ^{1} \text{ Personal communication, The late Sir John Bennett, uncle of the school girl, circa 1986.} \]
Table 2.1  Knowledge from the past

<table>
<thead>
<tr>
<th>Wholism</th>
<th>Te Whare Tapa Whā is regarded as a holistic approach to health and well being.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Māori social system</td>
<td>This is based on whakapapa and the lore of tapu.</td>
</tr>
<tr>
<td>Oral traditions</td>
<td>Pre-European Māori culture was based on oral traditions with knowledge and information being transmitted from one generation to the next by word of mouth.</td>
</tr>
</tbody>
</table>

Table 2.2  Future knowledge

<table>
<thead>
<tr>
<th>Social and cultural diversity</th>
<th>The world is not what it was. Māori are a diverse population group within contemporary New Zealand society and as such it is appropriate that the diversity of what “being Māori” is to different Māori people is acknowledged.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Treaty of Waitangi</td>
<td>The Treaty provides a framework for research methodology based on the three Treaty Articles. This gives Māori the right to include “Māori cultural experience” as a necessary part of “the development of Māori knowledge.”</td>
</tr>
<tr>
<td>Responsiveness to Māori</td>
<td>This is concerned with consultation with Māori for specific health research proposals and is a requirement to be addressed in health research applications to the Health Research Council and other funders and for Ethics Committee applications.</td>
</tr>
</tbody>
</table>
2.1.4 Mātauranga Māori (Māori Knowledge)

Cunningham also discusses what he identifies as a “taxonomy for Māori research.” This includes research that involves Māori, Māori centred research, and kaupapa Māori research. He describes “Māori centred research as “Māori data collected and a Māori analysis applied, resulting in the provision of Māori knowledge.” Kaupapa Māori research whilst it may incorporate the criteria of Māori centred research has other dimensions. Cunningham would not go to the extent of providing a definition of kaupapa Māori research but instead described the characteristics of kaupapa Māori research as:

(i) A high degree of involvement of Māori at all levels
(ii) A range of contemporary tools may be used to collect Māori data
(iii) A Māori analysis is always applied
(iv) It always results in Māori knowledge.

He describes the resulting Māori knowledge as a Māori analysis of Māori data. The critical aspect of a Māori analysis is that “Māori experience is at the centre of the theoretical base.” Although Cunningham was not bold enough to offer a definition of kaupapa Māori research, he outlined what other Māori authors had to say on the subject:

*Research is culturally safe, which involves the mentorship of kaumātua, which is culturally relevant and appropriate...*  
(Irwin 1994, as cited in Cunningham 1998)

*Research by Māori, for Māori and with Māori.*  
(L Smith 1995)

*Māori health research requires the development of new methodologies that will better measure and reflect Māori health as designed by Māori.* (Durie 1996)
Cunningham does however offer a rationale for kaupapa Māori research encompassing five specific criteria:

(i) Māori epistemology is “central to kaupapa Māori research.”
(ii) The Treaty of Waitangi provides for the right of a distinct Māori position based on the Māori view of knowledge.
(iii) Māori development is an outcome resulting from a new knowledge base that provides evidence for the development of policies and service which meet Māori needs and expectations.
(iv) Capitalising on the investment in Māori medium education.
(v) Internationalisation in which kaupapa Māori research may provide a major contribution to indigenous approaches on a global basis.

Cunningham concludes that “kaupapa Māori research is formative. It has its own methodologies and may employ a range of contemporary and traditional methods.” In so doing, Māori knowledge is created. The next question therefore is to attempt to define exactly what is Māori knowledge.

Royal (1998) provides a simple Māori answer. He defines mātauranga Māori or Māori knowledge as, “Māori knowledge is created by Māori to explain their experience of the world.” In the development of Māori knowledge, Royal poses two questions regarding methodology, “by what process or processes is mātauranga Māori created?” and “What is the nature of that process?” The response to those questions is whakapapa. Royal makes the claim that whakapapa or genealogy can be used as a legitimate research methodology. That is, what has occurred in the past is the major influence on where we are today. That may seem on the surface to be too simplistic, but what Royal is saying is that “whakapapa is a way of organising information into a coherent form.”
Royal provides a framework for Māori research which he names, Te Whare o te Mātauranga Māori: Te Ao Mārama. This translates as the “House of Māori Knowledge: The World of Light”. Tāne-mahuta, God of the Forest separated his parents, Rangi-nui and Papa-tū-ā-nuku and so brought light and knowledge into the world. Tāne also ascended to the heavens and brought back the three baskets of knowledge for the benefit of humankind. Royal states that “the world in which we currently reside is called Te Ao Mārama”. He describes six concepts which arose out of Te Ao Mārama view of the world and by perpetuating these six concepts one is perpetuating Te Ao Mārama. The six concepts are:

(i) **Rangatiratanga**. This is concerned with leadership. Royal defines leadership as “the ability to bind (ranga) groups (tira) together.”

(ii) **Manaakitanga**. This concept “points to the mutual elevation of mana in an encounter or scenario”.

(iii) **Whanaungatanga**. This is concerned with relationships. Royal expresses this concept as “interconnectedness of all things and this is shown in whakapapa”.

(iv) **Tohungatanga**. This is concerned with “expertise and skill”.

(v) **Ūkaipō.** Royal contends that these are ‘those spaces and places where one is nourished’, in particular “the mother’s breast”.

(vi) **Kotahitanga**. This “denotes the unity of all things in the world”.

This leads Royal to develop a definition of “mātauranga” or knowledge as, “mātauranga Māori is created by Māori humans according to that world view entitled ‘Te Ao Mārama’ and by the employment of methodologies derived from this world view to explain the Māori experience of the world.”
2.1.5 *Rangahau Māori* (Māori Research)

The word, “*rangahau*” would translate as “research". Royal argues that “*rangahau*” can only be applied to research that is conducted within the “Te Ao Mārama” paradigm of knowledge and by using the *whakapapa* methodology.

Royal stresses that the theory of Māori knowledge that he has outlined is currently under development at Te Wānanga-o-Raukawa and is a draft theory only which will undergo considerable debate. Be that as it may, the Māori knowledge theory provides a valuable background and important *whakapapa* to the methodological approach undertaken in this thesis.

Two other basic elements of Māori research are *tikanga* (customs) and values. E.T. Durie (1998) discusses both *tikanga* and values in the context of research activities.

The word “*tikanga*” can be translated to mean custom or customary practices. E.T. Durie makes the point that *tikanga* should not be used in the same European context as “rules". *Tikanga* he states is the Māori word for custom “which does not denote a set of rules" and that “*tikanga*, according to the Williams dictionary is a derivative of *tika*, which is fair, true or just, or a proper line of action, as some translators have put it.” Therefore Māori research for the development of new Māori knowledge must take account of *tikanga Māori* or Māori customary practice. An example of a “proper line of action” would be the observance of *te kawa o te marae* (marae etiquette or protocol) when engaging with Māori, regardless of the environment.

Values are the second element that Durie discusses. He describes the core values of *rangahau* or Māori research as the value system composed of the following criteria:

(i) *Whanaungatanga*: kinship bonds
(ii) **Manaakitanga:** caring for others

(ii) **Rangatiratanga:** the attributes of rangatira

(iv) **Utu:** the maintenance of the harmony of balance.

These criteria are taken for granted within the day-to-day activities of the marae. In general they are unseen; reflected by action and deeds rather than by words. Their application to Māori research is no less important in that, in order to gather specific Māori data and to provide an appropriate Māori analysis, these values would be adhered to and upheld.

Another model for Māori health research is Te Whare Tapa Whā. This is a Māori view of health and well-being which Durie (1998) describes as being “compared to the four walls of a house, all four being necessary to ensure strength and symmetry, though each representing a different dimension; *taha wairua* (the spiritual side), *taha hinengaro* (thoughts and feelings), *taha tinana* (the physical side), *taha whānau* (family)." This concept of health “is an interaction of *wairua, hinengaro, tinana* and *whānau.*”

Te Whare Tapa Whā has also been used as a theoretical framework for undertaking *kaupapa Māori* research. Glover (2000) used this paradigm for her PhD thesis, “The Effectiveness of a *Māori Noho Marae* Smoking Cessation Intervention: Utilising a *Kaupapa Māori* Methodology.” Glover (2003) explained that her choice of this paradigm was because,

Te Whare Tapa Whā is attractive for its simplicity, its metaphorical resonance for Māori, and its basis in a Māori world view, which will help achieve an understanding of scientific findings beyond academia.
Glover points out, however, that some Māori health researchers have found Te Whare Tapa Whā “too limiting” as a theoretical framework. She found that for her, this was not the case as its simplicity had the “ability to encompass all aspects of phenomena within its categories.” She justified her approach on the basis that although “the compartmentalisation into four categories is artificial and highly debatable” it helped to communicate and understand a behaviour (in this case, smoking) simultaneously driven by each aspect at once. The importance of her approach was the incompatibility of mātauranga Māori and Western theory which had “created a tension” throughout her project. She stated that a “Western explanation of smoking seemed to exclude a Māori understanding” but the use of Te Whare Tapa Whā appeared to minimise differences.

Another weakness of Te Whare Tapa Whā identified by Glover was that the model as a research framework “is a whare floating in the air. It is not grounded and therefore exists in isolation of a socio-political and historical context, a necessary component of kaupapa Māori analysis.” In order to overcome this shortcoming she incorporated the Te Tai Tokerau addition of Te Ao Tūroa which she used in its broadest sense to include a variety of environments: physical, social, political and historical.

In this thesis it would be very easy to use Te Whare Tapa Whā as the theoretical framework for a review of Māori oral health services. For example:

* Te taha tinana would encompass the biological, pathological, and epidemiological status of Māori oral health.
* Te taha hinengaro would encompass the mental and psychological impact of oral health status on Māori health and wellbeing and attitudes to oral health care.
However, rather than use a model that is already there, even though it has been used and proven to be valid and reliable and is very convenient, I have chosen to explore the development of a model based on a literature review of kaupapa Māori research. There was a need to move beyond the simplistic framework of Te Whare 1apa Whā in order to examine in detail the issues surrounding Māori oral health service delivery in three very different Māori oral health providers.

Te Rōpū Rangahau Hauora Māori o Ngāi Tahu of the Dunedin School of Medicine had developed a very clear philosophy of Māori health research. This kaupapa was presented by way of both an oral and poster presentation to Ngāi Tahu at their Hui-Ā-Tau (Annual Conference) at Tuahiwi Marae in November 1996 where it received the full support of Ngāi Tahu. Broughton described the process of Māori health research as being:

(i) The gathering together of information.
(ii) Information about us as Māori people.
(iii) Upholding mana Māori.
(iv) Ensuring that ethical issues are bounded by *tikanga Māori me te kawa o te marae*.

(v) Giving the information back to *iwi*.

Māori people then have a greater understanding and appreciation of their own health status. The outcome is that Māori become empowered because of an informed knowledge base of *hauora Māori*. Thus partnership, protection and participation can become a reality, as guaranteed under Te Tiriti o Waitangi. The intended outcome is Māori can move towards an increasing security of:

(i) The enhancement of a healthy environment.

(ii) *Tino rangatiratanga* which allows for control, responsibility and autonomy of *hauora Māori* to reside with Māori.

(iii) The elimination of negative lifestyle factors.

(iv) Being in a position to effectively address their own health needs as Māori through greater access to resources.

(v) Developing intervention strategies that are appropriate for Māori.

(vi) Providing evidence that supports the development of appropriate health services for Māori.

The methodology of Māori health research includes consultation that ensures:

(i) *Kaumātua* guidance.

(ii) Upholding *mana Māori*.

(iii) There are no conflicts of *tapu* and *noa*.

(iv) *Whānau, hapū* and *iwi* approval.

(v) *Whānau, hapū* and *iwi* ownership.
Undertaking *rangahau*, or research within a Māori methodological framework does, however, come against barriers. The most common barrier experienced by many Māori undertaking Māori research activities is that they may find their approach and methodology regarded as doubtful or lacking in scientific robustness by mainstream researchers. This notion was highlighted by Murchie (1984) in the major Māori health research project, *Rapuora, Health and Māori Women*, in which the foreword stated:

> It is a pioneer venture by Māori women into large scale research - a scientific field fraught with obstacles. Many times in the past the Māori has been observed, dissected and frozen in sometimes unflattering and unpalatable figures. Often though, discussion and understanding of the various parts have never been followed through to a discussion and understanding of the whole. This report changes that.

The conclusion to Rapuora stated:

> The Rapuora survey has shown that Māori can play key roles in research. Despite what at the start seemed an insurmountable handicap of lack of training in research techniques and an inexperience of the terminology used in the planning and in the processing of results, an amateur non-professional organisation has proved a point. Māori can carry out research.

> Rapuora could be a trail blazer for future research. This research provides only basic information on the health of Māori women. It is a guide to action and an affirmation that the Māori can conduct valid scientific research projects successfully.

Mutu (1998) also identifies barriers to Māori research and the development of *mātāuranga Māori*. She comments, "My extensive training in Western academic research told me that different cultural approaches should have equal validity."
However, she found that this was not the case. She found that it caused her “considerable consternation” to “redefine and completely reshape my kaumātua’s project to fit someone else’s cultural requirements” with the result that an application for funding “lacked the cultural integrity and validity that had been so clear in the original shaping of the project.” Mutu concluded that “it is the wise use of knowledge that brings us to Te Ao Mārama, not its abuse or misuse.”

Barnes (2000) has also been confronted with “the argument that there is no such thing as kaupapa Māori research.” She found in her experience that “the need to define, discuss or explain its existence in itself serves as a reminder of the power of colonisation.” She states that “kaupapa Māori research begins as a challenge to accepted norms and assumptions about knowledge and the way it is constructed and continues as a search for understanding within a Māori worldview.” In order to achieve this “kaupapa Māori research may be seen as taking a distinctive approach and having underlying principles or aspects which are based on a Māori worldview”. Smith (1998) has, however, “promoted the merits and necessity of embracing methodological approaches that validate Indigenous experiences, as well as effectively conceptualise and record Māori knowledge along side that of Western research.”

2.1.6 Limitations of kaupapa Māori research

Kaupapa Māori research is research that is essentially by Māori about Māori for Māori. It would be not unreasonable to assume, therefore, that all others are excluded from engaging with, participating in or responding to Māori researchers in a kaupapa Māori research process. In reality, this is not the case at all. The one critical factor is that kaupapa Māori research is Māori focused. Being Māori focused ensures that the research question(s) come from within te ao Māori in that they may adhere to a particular Māori perspective, they may be couched in Māori terms or they may reflect a Māori view of the world. As a result of the kaupapa Māori research process Māori
data is generated and a Māori analysis is applied resulting in new Māori knowledge. Does it follow that the subsequent Māori knowledge is for Māori alone? That this question is posed illustrates an inherent weakness of kaupapa Māori research. Whilst it is anticipated that the results of kaupapa Māori research would impact upon Māori in the first instance, the research results must have a much wider impact. The vehicle for such an impact is through the dissemination of kaupapa Māori research to the broader research community of interest which includes academic, local body, government and community agencies and organizations. There is a subsequent expectation that there would be a greater understanding of the particular Māori issues and a greater potential to bring about some consequent change or difference for the betterment of not only Māori, but society as a whole.

In Māori health service provision there are many non-Māori people (or tauiwi) working within the industry as health professionals, administrators or community health workers and their contribution is valued just as much as the Māori contribution. Tauiwi involvement in kaupapa Māori research, either as co-researchers or participants, should not hinder the kaupapa Māori research process in any way. Cram et al. (2006) describes a situation where some Māori stakeholder groups would only be involved in a research project “if it was by Māori for Māori.” This particular research was part of a larger study for which Cram was responsible for the Māori component. The situation was overcome by ensuring that the “remaining Māori stakeholder groups be facilitated by Māori, and that the project effectively ‘ring-fence’ the Māori data for an initial, ‘by Māori, for Māori’ analysis.”

Another limitation of kaupapa Māori research is that there is some uncertainty about the genre as a whole. This uncertainty stems from the seemingly ‘newness’ of kaupapa Māori as a legitimate research entity in its own right. The point at which kaupapa Māori research began to gather momentum was post-1990. The 150th anniversary of
the signing of the Treaty of Waitangi in 1990 resulted in a major expression of Māori assertiveness within New Zealand society as a whole. The 1990 commemorations saw Māori becoming more vocal about the government honouring the Treaty and challenging the government to uphold the Articles of the Treaty. The emerging *kaupapa Māori* research was seen as an assertion of Article II in which Māori retained *tino rangatiratanga* (chieftainship or self-determination) over research which may impact upon Māori. Throughout the decade of the 1990s Māori health research units were established at the Wellington School of Medicine (Te Roopu Rangahau Hauora Māori A Eru Pōmare) and the Dunedin School of Medicine (Te Roopu Rangahau Hauora O Ngāi Tahu). The Christchurch School of Medicine, Massey University and Auckland University also established Māori health research capacities within their respective institutions. At the same time the Health Research Council of New Zealand also established a Māori Health Research funding arm with its own committee and targeted funding. The acceptance of these new research entities, the research they were undertaking and the research processes they developed have taken some time to be accepted by 'mainstream' researchers. For example, the Ngāi Tahu Māori Health Research Unit at the Dunedin School of Medicine published the results of some of their research projects (*Broughton et al.* 1997 and *Rimene et al.* 1998) as monographs for dissemination back to Māori communities. A perception arose within the Unit that these monographs would not be recognized as legitimate research publications. It was regarded as imperative that research results were published in a form that was “accessible to *whānau*, *hapū* and *iwi*. Not only that, they must be published in a form that *whānau*, *hapū* and *iwi* can readily relate to” (*Ngāi Tahu Māori Health Research Unit* 1997). The then Dean of the Dunedin School of Medicine commented that the most effective way to bring about change within a community was to have an appropriate means of reporting back to that community. The uncertainty of *kaupapa*

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2 Personal communication, Professor W. D. Gillespie, 1998.
Māori research as a discipline in its own right has dissipated to some extent, mainly through partnerships and collaborations with mainstream non-Māori researchers and the wide dissemination of kaupapa Māori research results. This has brought about a consequent application of research results for a beneficial health outcome and hence a wider understanding of kaupapa Māori research.

An inherent weakness of kaupapa Māori research is an implication that all Māori are the same. An assumption may be made that all Māori who participate in a research project as either researchers or the researched all share the same beliefs, attitudes, values. Broughton et al. (2000) have clearly demonstrated that this is not the case. They investigated Māori ethnicity and identity in the Christchurch Health and Development Study and found that there is a diversity of Māori realities for people with Māori ethnicity. Gibbs et al. (2004) reported on a case where “one patient was strongly opposed to participation in Māori cultural activities and any insistence on this course for him may have only increased his resentment of contact with mental health services.” The diversity of Māori realities highlights the broad scope of Māori identity within contemporary Māori society. Even though Māori society is based on whānau, hapū and iwi infrastructures, these entities in turn have inherent differences in their own right. Contemporary Māori society also includes Māori communities and Māori people who may not participate in or be associated with traditional or ancestral Māori cultural constructs such as marae. That kaupapa Māori research is able to embrace Māori as an homogenous mix rather than one unified whole would seem to be at variance with the very precise and exact nature of scientific research. This highlights the notion that ‘Māori is Māori’ no matter what the degree of Māori identity or what the ability to kōrero Māori happens to be for an individual. Kaupapa Māori research must take account of the diverse Māori realities whilst at the same time upholding the very essence of what ‘being Māori’ actually represents (Broughton 1993a).
A potential weakness of any research methodology, especially with regard to qualitative research is bias. Could bias occur on behalf of both the researcher or the participant? It is not inconceivable that a researcher could be biased through having a particular agenda or outcome to be achieved and could lead an interviewee or focus group along a particular pathway. Alternatively, a research participant may want, for whatever reason to provide biased responses in a research survey or questionnaire. Broughton and Lawrence (1993) in a qualitative study of Māori women and smoking utilized an opportunistic sampling technique by accessing the research participants wherever they happened to be, at hui, marae, Māori organizations and Māori social occasions. One participant used stand-over tactics on her sister, a smoker, to participate by stating, “C’mon Sis, I’m going to make sure you do this survey.” On the other hand, another woman approached stated, “I’m not going to do your blinkin’ survey. I’ll only end up being preached at again!” Kaupapa Māori research however is subject to the same scrutiny and robust scientific procedures as ‘mainstream’ research to ensure that bias does not impact detrimentally upon the research results.

Kaupapa Māori research that includes a quantitative component is subject to the same statistical analysis as any other quantitative research regardless of how the research data were collected. An inherent weakness is that the Māori ethnic group within a larger study may be so small that a valid and reliable statistical analysis cannot be undertaken. To overcome this problem, a Māori cohort may be over-sampled to ensure that an adequate sample size is generated. The idea of “equal explanatory power” has been proposed as one way of ensuring that a small sample size is not a problem in the research methodology. Regardless of the methodology for generating a representative Māori sample group and the subsequent data, what is important is that a Māori analysis is applied to the data. This is critical as the research data could be
interpreted in very different ways. For example\(^3\), a non-Māori psychiatric nurse interpreted the behaviour of a Māori psychiatric patient who ‘rose at 5am and appeared to rant and rave at the walls’ as an acute psychotic episode. A recommendation was made to ‘increase his medication’. The Māori psychiatric team had a very different interpretation of this situation. The patient’s behaviour was the normal behaviour for this particular patient – he was an adherent of the Ringatū faith and he would get up early each morning to recite the Psalms to ensure that he had not forgotten them.

Whilst this is an example from a clinical scenario it does illustrate the importance of a Māori assessment, a Māori interpretation of results and the utilisation of a Māori analytical process, what ever that may be.

The one major limitation of conducting *kaupapa Māori* research is that it may not be a straightforward process and can be fraught with difficulties, especially with regard to the actual research process itself. It takes a lot of time. Time taken to *korero* with Māori stakeholders about a particular project, in the development of a research project, may take several cups of tea over a number of visits. In the long run, for a successful outcome this is time well spent. Tuuta *et al.* (2004) in an evaluation of the *Te Kauhua Māori Mainstream Pilot Project* found that their *kaupapa Māori* research approach had not been an easy one. The researchers stated:

> In *kaupapa Māori* research the wishes and directions indicated by the research *whānau* take precedence. During the process of data gathering, writing up the data, and compiling this report we have made efforts to adhere to the principles of *kaupapa Māori* research. This has not been easy and there are some aspects where this has not been possible. Often projects like this are not initiated by Māori, but have involved Māori. This one was ‘for Māori by Māori’. The people managing the project from the Ministry of Education are Māori, and the researchers out in the field are Māori.

\(^3\) Personal communication, Dr K Skegg, Fourth Year Medical Class seminar, Psychological Medicine: *te taha hinengaro*, 1999.
The researchers felt embedded within the research, sharing the experiences facing many of the people in the project.

That there are limitations and weaknesses in conducting *kaupapa Māori* research is fully acknowledged. Other barriers to conducting research are access to adequate research funding, the availability of a trained and qualified Māori health research workforce, the reliability and validity of ethnicity data, the proficiency of some Māori health researchers in *te reo Māori* and the provision of both scientific and cultural support for those endeavoring to undertake *kaupapa Māori* research. The one important criteria to overcome the limitations in *kaupapa Māori* research is that researchers must be confident in two worlds, both *te ao Māori* and Western science.

2.1.7 A framework for *kaupapa Māori* research

A framework for Māori community development was developed by the Māori Health Commission (1999a) which was "outcome focused and designed to empower communities to increase their capacity to control, to respond, and to be responsible, for their own development." The framework is based on a number of principles which the Commission recognised as being crucial for Māori to improve their health. These principles were subsequently adapted to provide the framework which would recognise Māori participation within the then current health sector. The principles are:

(i) *Rangatiraanga* (Māori leadership)

Māori control over their own health improvement.

(ii) *Whakakohitanga* (Unity)

A holistic approach to health improvement which is culturally valid and which maximizes coordination within the health sector and provides more effective services for Māori.
(iii) **Whakawhānuitanga** (Diversity)
Recognising and catering for the diverse needs and aspirations of Māori individuals and collectives.

(iv) **Whanaungatanga** (Relationships)
Enabling culturally appropriate forms of relationship management and associations to be fostered and sustained.

(v) **Māramatanga** (Enlightenment)
Raising Māori awareness and choice.

(vi) **Whakapakari** (To strengthen)
Taking a developmental approach to Māori health improvement which recognizes the need to increase overall Māori health capacity and capability.

These principles described by the Māori Health Commission for Māori health development are not far removed from the principles and processes of *kaupapa Māori* research as enunciated by Cunningham, Durie, Royal, Glover, Mutu, Barnes and Broughton. What is of significance is that there are a number of key elements in *kaupapa Māori* research. These elements are the recognition that *kaupapa Māori* research encompasses a particular Māori worldview; that *kaupapa Māori* research encompasses a number of methodological approaches; and that the outcome of *kaupapa Māori* health research contributes to an improvement in Māori health.

From this review of the literature regarding *kaupapa Māori* health research there are common themes of *tikanga, rangatiratanga, whakapapa, mātauranga, whanaungatanga, whakakotahitanga, and māramatanga*. These themes provide the framework for this thesis under a *kaupapa Māori* methodology. The framework provides the means of organising the information in this research project that is relevant and appropriate for Māori. Therefore the framework to be used is presented in Table 2.3.
Table 2.3: Kaupapa Māori research framework

<table>
<thead>
<tr>
<th>PRINCIPLE</th>
<th>APPLICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Rangatiratanga</em> (Māori leadership)</td>
<td>A Treaty of Waitangi based approach which recognises Māori self determination.</td>
</tr>
<tr>
<td><em>Whakakotahitanga</em> (Unity)</td>
<td>The recognition of what “being Māori” means by embracing universal aspects of Māori culture and belief systems.</td>
</tr>
<tr>
<td><em>Whakapapa</em> (Lineage)</td>
<td>The recognition of the past, where Māori have come from, have been and are going. This is a fundamental construct of Māoritanga.</td>
</tr>
<tr>
<td><em>Whakawhānuitanga</em> (Diversity)</td>
<td>The recognition and celebration of differences within Te Ao Māori.</td>
</tr>
<tr>
<td><em>Whakawhanaungatanga</em> (Relationships)</td>
<td>The recognition of the many branches and associations, interactions and relations within and without te ao Māori.</td>
</tr>
<tr>
<td><em>Māramatanga</em> (Enlightenment)</td>
<td>The increase in knowledge and the application of that knowledge for a beneficial outcome.</td>
</tr>
<tr>
<td><em>Whakapakari</em> (To strengthen)</td>
<td>The recognition of the need for Māori institutions to continually grow and develop for the benefit of all.</td>
</tr>
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</table>

Whilst this framework is unique in that it has been developed specifically for this project it is no less valid. It is an assertion of *rangatiratanga*. It is an exploration of Māori realities in a modern world. Moana Jackson (1998) provided a justification for this approach when he spoke at the Māori Health and Development Conference at Massey University in 1998:

In the late 20th century one of the most common things directed at our people is you have to get “real”. But it seems to me that “getting real” still means we have to be like them. For reality is a human construct and the reality with which our people lived was made and shaped by us. The world in which we live today is different. We are a different people. But it seems to me we still have the wit and wisdom and indeed the right to define our own reality and to demand that the other party to the Treaty respect that reality ... it is the hope that we reclaim for ourselves, our own reality. That we be brave enough not just to do research which will have a practical application in the world that it is, but rather that we
are visionary enough to undertake research that will help our people in a world as it may be.

That we be not afraid to dream, and that we accept that if we are spiritual people, and I believe we are, then we understand that the spirit is the base of our dreams. For if we conduct research in a dreamless world then we do not create a vision of hope for our mokopuna.

I looked the word ‘research’ in the dictionary and it comes from the old French word - to search again. The word ‘qualitative’ as in ‘qualitative research’ has to do with finding qualities. I hope that in our research we find the qualities which made us strong and which made us unique. That we search again for the faith in ourselves so that we are no longer trapped in a box which first put us in a category of a primitive inferior.”

2.2 Te Whakamutunga (The Conclusion)

An appropriate kaupapa Māori research framework has been developed and justified within the boundaries and tenets of te ao Māori, the Māori world. The seven criteria of the kaupapa Māori framework are: Rangatiratanga (Māori Leadership); Whakakotahitanga (Unity); Whakapapa (Lineage); Whakawhānuitanga (Diversity); Whakawhanuangatanga (Relationships); Māramatanga (Enlightenment); and Whakapakiri (Capacity Building). This approach is a reclamation of a distinct and unique Māori reality. The application of this framework will be a valuable guide for the future development of oranga niho (oral health) services for Māori.
Chapter 3

Te Tikanga Rangahau
(The Research Methodology)

3.1 Te Kōrero Tuatahi (Introduction)

Te tūmanako (the aim) of this study was to review Māori oral health service provision utilising a kaupapa Māori methodology. As this was a study about Māori health, it was appropriate that it was conducted by Māori with a Māori perspective whilst still maintaining the robustness, validity and reliability of health research. The specific aims of the study were: firstly, to develop an appropriate framework of kaupapa Māori research methodology to be utilised in this study; secondly, to undertake a review of the literature of Māori oral health (to include traditional Māori beliefs and practices of Māori oral health, Māori oral health status and oral health service delivery for Māori); thirdly, to document Māori oral health initiatives (to include Māori oral health education resources and oral health promotion activities); and fourthly, to review the development, implementation and operation of Māori oral health services within three different types of Māori health service provision (a mainstream service, an īwi or community-based service, and a service that is in partnership with another health provider). The three designated Māori oral health providers were:

(i) Te Whare Kaitiaki at the University of Otago Dental School, Dunedin.

(ii) Te Ātiawa Dental Service, an īwi-based service in New Plymouth.

(iii) Tipu Ora Dental Service, in partnership with the School Dental Service, Lakeland Health, Rotorua.
3.2 Kaupapa Māori Research

A kaupapa Māori framework was developed for this study. This was appropriate as Māori have often felt disadvantaged as assessment tools used to measure outputs, outcomes and effectiveness of Māori initiatives have not always taken appropriate account of Māori philosophy, custom or processes. A recent example of this situation is the Education Review Office (ERO) which adopted new criteria for the review of Kura Kaupapa Māori (Māori language immersion schools) based on Māori ideologies (New Zealand Education Review 2001). The significance of a kaupapa Māori methodology is that it affords a means of organising and analysing the information that has been generated, within a Māori cultural context resulting in a research process that is both meaningful and relevant for Māori. The kaupapa Māori framework (as discussed in Chapter 2) was developed by undertaking an extensive literature review of this subject. The framework, consisting of seven criteria and their application to Māori oral health, is detailed in table 3.1.
Table 3.1 Application of kaupapa Māori research framework for Māori oral health

<table>
<thead>
<tr>
<th>PRINCIPLE</th>
<th>APPLICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rangatiratanga</strong> (Māori leadership)</td>
<td>Utilises a Treaty of Waitangi based approach to Māori oral health services and their development.</td>
</tr>
<tr>
<td><strong>Whakakotahitanga</strong> (Unity)</td>
<td>This embraces Te Whare Tapa Whā model of health and wellbeing to describe Māori oral health.</td>
</tr>
<tr>
<td><strong>Whakapapa</strong> (Lineage)</td>
<td>Affords an historical approach in the development of Māori oral health services.</td>
</tr>
<tr>
<td><strong>Whakawhānuitanga</strong> (Diversity)</td>
<td>The diversity of Māori oral health services.</td>
</tr>
<tr>
<td><strong>Whakawhanaungatanga</strong> (Relationships)</td>
<td>Interactions and relationships in Māori oral health services.</td>
</tr>
<tr>
<td><strong>Māramatanga</strong> (Enlightenment)</td>
<td>Māori oral health education and promotion.</td>
</tr>
<tr>
<td><strong>Whakapakari</strong> (To strengthen)</td>
<td>The capacity building of Māori oral health services.</td>
</tr>
</tbody>
</table>

3.3 Tikanga Māori (Māori Custom)

Māori custom and values were upheld in undertaking this review. The customs and values that were embraced included the following:

* Kaumātua guidance: The kaumātua for the project were Mr Pihopa Kingi and Mrs Inez Kingi of Ōhinemutu, Rotorua and Dr Tony Ruakere of Te Ātiawa Medical Centre, New Plymouth. Discussions were undertaken with them in planning the project and seeking their advice and support. Mr Karaka Roberts, a kaumātua resident in Dunedin was also consulted regarding aspects of Māori cosmology.
Upholding *mana Māori*. This is the acknowledgement and respect for Māori aspirations, beliefs and values in the research process. It also involves the application of the both the Articles (governance, Māori leadership and equity) and the principles (partnership, participation and protection) of the Treaty of Waitangi in the research process.

*Ethical issues.* In a Māori cultural context, ethical issues are grounded in and bounded by *tikanga Māori* (Māori custom) and *te kawa o te marae* (*marae* etiquette and protocol).

*Respect for the concept of* tapu *(the state of being set apart).* This is to ensure that there are no conflicts of tapu and noa (free of tapu, neutrality) in the research process.

*Tautoko* (Support). *Iwi/Māori* provider support is essential in such undertakings. Letters of support were obtained from the participating Māori providers which were included in the Health Research Council grant application and the Ethics Committee application.

*Iwi/Māori* ownership of research *kōrero*. Mr Pihopa Kingi and Mrs Inez Kingi were the *kaitiaki* of this project for and on behalf of the Tipu Ora Trust Board. Dr Tony Ruakere was *kaitiaki* of this project for and on behalf of Te Ātiawa Dental Centre. In Otago the investigator reported to the *Mana Whenua* Health Working Party, a combined *rūnaka* Working Party accountable back to the Ngāi Tahu *rūnaka* of Otākou, Huirapa and Moeraki.

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3.4 The Research Process

3.4.1 Research Funding
A grant application was made to Kaunihera Rangahau Hauora o Aotearoa (Health Research Council of New Zealand) to provide funding for this project. This was successful with effect from 1 July 2002 to 30 June 2004. The funding was to cover the costs of travel to the North Island to engage with oral health providers; for hui and koha; and for administrative and logistic support.

3.4.2 Ethics Committee Approval
Ethics Committee approval to undertake this review was granted by the Otago, Taranaki and Bay of Plenty Ethics Committees with Otago being the Lead Committee. The consent form and participant information sheet is documented in the appendix.

3.4.3 Literature Review
An extensive literature review was undertaken which included not only refereed journals but also history publications, Māori texts and publications, government agency reports (both internal and published reports), dental reviews (including dental health sector monographs, internal reports, committee reports and minutes), magazine articles, newspaper reports and historical texts. The archives of the now defunct Māori Health Commission was also a very valuable source of historical information and documents.

3.4.4 Qualitative Data Collection
The research was essentially a qualitative research project. Interviews were conducted with those responsible for the development, implementation and operation of three quite distinct Māori oral health services: an iwi-based service (Te Ātiawa Dental Service in
New Plymouth); a service in partnership with another provider (Tipu Ora Trust in Ōhinemutu, Rotorua); and a service based in mainstream (Te Whare Kaitiaki at the University of Otago Dental School). The interviewees were recruited on the basis of their extensive involvement with their respective oranga niho service.

The interviewees were initially approached during the original development of this project and were all very supportive. The interviews were conducted kanohi ki te kanohi (face to face) in a relaxed and informal atmosphere. They began with the Māori protocol of mihimihi (greetings and introductions) and when deemed appropriate karakia (prayer) were also said. On some occasions the interviews were a group interview or focus group of up to three people. Project information sheets and a consent form were given to the interviewees. With two of the providers, the Consent Forms were not signed. One presented them back to the interviewer with a body language which could only be interpreted as “this is not necessary”. The other provider stated that, “This is not tikanga Māori”. The interviewees were more than happy to participate and spoke frankly and openly of their individual experiences in the development, implementations and operation of their respective oranga niho service. This was a very clear demonstration of their trust and respect for the researcher.

A rigid questionnaire was not used, but the basic questions covered were:

* What were the issues involved in the establishment of your oranga niho service?
* What were the barriers that you encountered in establishing your service?
* How did you overcome those barriers?
* Were there any particular issues that you have identified in the operation and management of your oranga niho service?
* Were there any barriers in the operation and management of your *oranga niho* service?

* How did you overcome those barriers?

* Where do you wish to take your service in the future?

The interviews were not tape-recorded but extensive notes were taken during the course of the interviews. The notes were transcribed and copies given back to the interviewees for their perusal, comment and alterations if deemed appropriate. The interview transcripts were organised into identified themes which had emerged.

The researcher attended a number of *hui* (conferences) and health conferences which provided a wealth of information on a whole range of Māori health service issues including: important insights, perceptions and attitudes towards Government, their policies and agencies; new ideas, innovations and recent developments in *oranga niho*; and access to some essential documents and references. The most important aspect of attending *hui* was the *hui kōrero* (conference discussions) which included formal speeches, dialogue, thoughts and oral presentations that were expressed within a totally Māori cultural context. *Hui kōrero* also includes informal discussions which occur within the confines of the *hui*. Most of the *hui* were on *marae* but this was not always the case. A complete list of all *hui* and conferences attended in undertaking this review is listed in the appendix. The information acquired through the *hui kōrero* process was noted down and catalogued. Within a Māori cultural context the information gained in this manner is no less valid as it is well recognised that “you only hear the real story on the *marae*.” It is often the case that information is forthcoming and opinions voiced that are not heard, recorded or documented anywhere else. The importance is that *hui kōrero* often typifies the real meaning, intent, beliefs and ideologies of Māori. This is because it is expressed openly and freely in public within an environment that is natural and appropriate for the
kaikōrero (speaker). This is an accepted norm for Māori in these situations. The speakers are all aware that many hui participants either tape record or document extensive notes of their kōrero.

3.4.5 Anecdotal Evidence

The researcher has been actively involved with the dental profession as a dental student (1974-1977), a hospital dental house surgeon (1978), in general dental practice (1979-1989) and a member of the Faculty of Dentistry (part-time 1979-1989 and as a full-time University staff member from 1989). During that time he has amassed a wealth of experience in engaging with Māori at all levels. As a result, considerable anecdotal evidence and experiences from these interactions provided an important dimension to this review of Māori oral health services.

3.4.6 Te Reo Māori (Māori language)

Māori language utilises both a short and long vowel. In this thesis vowel length has been marked by macrons. The early published works of Dr Ranginui Walker quoted in this thesis (Walker 1990) did not engage in this linguistic practice. However, the use of macrons has now become an accepted conventional practice. Māori words used in this thesis have been italicised except when used as a proper noun apart from some Māori words which have become part of the distinctive New Zealand vocabulary. Passages of text which are quotations from the qualitative data have been italicised. In this case the Māori words remain in the standardised form. The Ngāi Tahu dialect has been used where appropriate where the ‘ng’ is replaced by a ‘k’. Where this has occurred the “k” has been under-scored as ‘k’. For example a rūnanga (tribal council) becomes ‘rūnaka’ in Kai Tahu dialect. Some confusion does arise as Ngāi Tahu people use both dialects,
moving freely between ‘Ngāi Tahu’ and ‘Kai Tahu.’ Ngā kupu (a glossary) of Māori words is in the appendix.

3.4.7 Māori World Views

The kaupapa Māori framework developed for this study presents a Māori world view of oranga niho. However, during the course of this study it became evident that there were numerous Māori world views, depending on where one was standing and in what direction one was looking. Hence the framework’s seven criteria revealed some overlaps in some issues which may give the perception of repetition. There were recurring themes such as the funding of Māori oral health services, for example. However, when the same issues were manifested, different perspectives and different analyses were made of them. This only served to highlight: firstly, the diversity of Māori thinking; secondly, the mutual respect for whānau, hapū and iwi Māori kawa (protocol) and tikanga (custom); and thirdly, the autonomy of Māori health providers.

3.5 Te Whakamutunga (The Conclusion)

The aim of this research project was to review Māori oral health service provision through the experiences of three distinctly different models (an iwi-based, a partnership-based and a mainstream-based service model) with a particular emphasis on the development, implementation and operation of their respective service. A kaupapa Māori research framework was developed to undertake this study.
Chapter 4

Rangatiratanga

(Māori Leadership)

4.1 Te Kōrero Tuatahi (Introduction)

Māori society is based on whānau (family), hapū (sub-tribe) and iwi (tribe). An individual person belongs to a whānau which belongs to a hapū which belongs to an iwi. This sense of belonging is the essential core of what ‘being Māori’ means as it gives both individuals and communities their identity as Māori (Broughton 1993a). However, the reality for some Māori today is that through social upheaval and migration, they may be isolated and dislocated from their ancestral links and tribal base. This does not lessen the fact that they may still choose to identify as Māori. This has given rise in the post-war era to the notions of ‘urban Māori’ and ‘urban marae’ to meet the cultural needs and aspirations of Māori who live away from their ancestral base or who may have lost the links with their hapū and iwi. Whatever the case, both traditionally-based Māori and urban-based Māori have recognised Māori leadership within their communities. Leadership of whānau is designated by kaumātua or respected elders. Leadership of hapū is designated by rangatira or chiefs. The mana over the whenua may be vested in the rangatira on behalf of the hapū collective. The leadership of an iwi is designated by ariki or paramount chiefs. The iwi may assert political and social control over the hapū who in turn may assert such controls in certain circumstances over whānau. Leadership then is an integral part of Māori society.

Leadership is also the driving force of governance. The government is elected to govern; the Ministry of Health develops and guides government health policy; the
District Health Boards purchases health services based on that government policy and health providers deliver those health services. At each level, leadership is critical. In an effort to ensure that the health needs of Māori are met, ongoing interactions between these levels of government and government agencies and Māori has been actively pursued. This has occurred in particular since the health reforms of the early 1990’s under the Health and Disability Act (1992) which separated the purchasing and providing of health services. With strong and robust Māori leadership, Māori were able to access resources to develop appropriate health services. Since the passing of this Act there was extensive development of Māori health service provision. In 1992 there were six Māori health providers\(^1\). By 2003 this had grown to 240 Māori providers with DHB contracts (Ministry of Health 2004a). The point of interaction between Māori leadership and government agency leadership is Te Tiriti o Waitangi.

### 4.2 Te Tiriti o Waitangi

On 6 February 1840 the Treaty of Waitangi was signed by Māori Chiefs (representing their *hapū* and *iwi*) and the British Crown. Thirty-nine northern Māori chiefs signed the Treaty on that day and subsequently a total of 539 Māori leaders throughout most of the country also signed (Orange 1987). The preamble to the Treaty stated that:

> Victoria, the Queen of England, in her concern to protect the chiefs and the sub tribes of New Zealand and in her desire to preserve their chieftainship and their lands to them and to maintain peace and good order considers it just to appoint an administrator, one who will negotiate with the people of New Zealand to the end that their chiefs will agree to the Queen’s Government being established over all parts of this land and (adjoining) islands and also because there are many of her

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\(^1\) Personal communication, Mr Rob Cooper, General Manager, Maori Health Division, Health Funding Authority, 1998.
subjects already living on this land and others yet to come. So the Queen desires
to establish a government so that no evil will come to Māori and European living
in a state of lawlessness...

The Treaty allowed Britain to establish a colony in New Zealand whilst Māori
retained their *tino rangatiratanga* (chieftainship) over their “lands, estates forests
fisheries and other properties”. Māori were also given “the same rights and duties of
citizenship as the people of England”. The Treaty was a fair and just document which
set out quite clearly and simply the expectations of both partners.

Under Article I, the sovereignty of New Zealand passed from the Māori chiefs to the
British Crown. “The Chiefs of the Confederation...give absolutely to the Queen of
England forever the complete government over their land.”

Under Article II, Māori were guaranteed the “unqualified exercise of their
chieftainship over their lands, villages and all their treasures”. The Queen of England
agreed to protect the chiefs, the sub-tribes and all the people of New Zealand with
regard to ‘*tino rangatiratanga*,’ their autonomy and self determination.

Article III is about equity. The Queen of England promised to “protect all the ordinary
people of New Zealand” and promised to give Māori “the same rights and duties of
citizenship as the people of England”.

History has shown that all three Articles of the Treaty were breached by the Crown,
Crown Agents, the Provincial Government and the Colonial Government, with the
major violations occurring throughout the latter half of the 19th Century. This
occurred through the alienation of Māori from their lands by unfair and corrupt land
sales, land confiscations as the result of the Land Wars of the 1860’s and through
unjust government legislation. As a result Māori were dislocated from their traditional
food sources, were denied their economic base, were unable to compete in the new
market economy, suffered cultural alienation and fragmentation of their society and were believed to be a ‘dying race’.

However, despite the hardships, negativity, alarming death rates, poverty, demoralisation and despair, Māori have survived. Today the Treaty Settlement process is redressing as far as it can, the wrongs of the past and restoring not only Māori welfare, wellbeing and advancement but also the mana of the whānau, hapū and iwi. Whilst it will take more than one generation for the realisation of socio-economic parity and the elimination of negative health and social statistics, it is strong Māori leadership that is driving the determination to have a better life. Today, the Ministry of Health recognises the Articles of the Treaty of Waitangi being described as:

Article I: Provides a duty of the Government to govern
Article II: Establishes a recognition of the sovereignty of Māori leadership
Article III: Requires the Government to treat Māori the same as all New Zealanders.

In addition to the three articles of the Treaty, three principles of the Treaty have been widely recognised. In 1986, Cabinet had agreed “that all future legislation referred to Cabinet at the policy approval stage should draw attention to any implications for recognition of the principles of the Treaty of Waitangi” (Department of Health 1986) The Treaty principles of partnership, protection and participation are recognised as a working framework for Māori advancement.

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2 Personal communication, Dr T Ruakere, Chief Advisor, Maori Health to the Minister of Health, 1999.
Today, Māori do not enjoy the same health status as non-Māori across all age groups and these disparities have been well documented, particularly by the late Professor Eru Pōmare (Pōmare et al. 1995). Some explanation for the health disparities can be attributed to the violations of the Treaty of Waitangi, with the resultant impact of a new and dominant colonising culture imposed upon a race of people. However, the factors affecting the health and well being of contemporary Māori are multifactorial, complex and are still not completely understood. Ajwani and Blakely (Ajwani et al. 2003) have demonstrated the widening gap that has occurred between Māori and non-Māori (based on a deprivation scale) for the two decades of the 1980s and 1990s. Therefore, to appreciate the health issues of Māori and the challenges that are required to meet those issues it is appropriate to consider the government’s response, the health sector response, the dental health sector response, and the Māori response, with a particular emphasis on disparities in oral health. The common theme that emerges in responsiveness to Māori health status is rangatiratanga or leadership.

4.3 The Government Response

The present New Zealand Labour Government is committed to addressing the disparities that exist in New Zealand between Māori and non-Māori. Regardless of the party politics of a particular government in power, each successive administration has had an explicit resolve to address the poor health of Māori under the guise of recognising the ‘special’ relationship between Māori and the Crown through the Treaty of Waitangi. However, in a review of Māori health policy over the 1990s, the National Health Committee (2002) criticised this approach as there was never any specified description as to “how the Treaty could be implemented with respect to Māori health.”
An attempt had been made in 1991 to develop a Māori health strategy by the Hon. Winston Peters, Minister of Māori Affairs in the then National Government. The Minister had brought together a think tank of expertise “to describe the current position of Māori in society, to recommend strategies to improve the position and to identify the Government’s role in Māori development, including an assessment of the current policy and delivery system of Māori Affairs”. The result was an important report, *Ka Awatea; The New Dawn* (Ministerial Planning Group 1991) which was embraced and supported by Māori throughout the country. The main outcome of the report was the recommendation for the establishment of a new specialist Māori agency with responsibility in the four areas of education, labour market, economic business development and health. In the nature of politics, Mr Peters was discharged as the Minister of Māori Affairs and exited the National Party. *Ka Awatea: The New Dawn* also disappeared along with the recommendations.

In 1993 the National Government’s objective for Māori health (Department of Health 1993) was:

> The Crown will seek to improve Māori health status so that in the future Māori will have the same opportunity to enjoy at least the same level of health as non-Māori.

With the establishment of the four Regional Health Authorities (RHA) under the new health reforms there was a requirement to enact this government policy. Each RHA appointed Māori Health Managers who developed a Māori health administrative infrastructure within their respective areas to develop and fund Māori health service provision. Through this development Māori were able to access resources and funding for the very first time to provide appropriate services in an attempt to meet their health needs. Within the Hospital Boards’ Māori health initiatives and services gradually developed in three main areas: Māori health liaison/community health workers, Māori...
mental health units and Māori health promotion. Māori tribal groups and Māori community/urban groups were also able to access funding to develop and provide a wide range of health services. In 1999 the four RHA's were amalgamated into one Health Funding Authority (HFA) with some responsibilities passing back to the Ministry of Health. Te Kete Hauora, the Māori Health Directorate was also established within the Ministry of Health with a new position of Chief Advisor, Māori Health.

In 1996 the Coalition Government of National and New Zealand First continued with the policy of "seeking to improve Māori health status". As part of the Coalition Agreement of December 1996 Ka Awatea was to be reinstituted. At the Cabinet meeting on 28 July 1997 it was noted (Cabinet paper 1997):

**OBJECTIVES FOR MĀORI DEVELOPMENT COMMISSIONS**

A noted that cabinet has agreed to the establishment of Māori Development Commissions for education, Health, Economic Development, and Employment and Training, and to their objectives and activities.

B noted the summary of objectives for the Commissions set out in the submission under CAB(97) 562 at page 2;

The Māori Health Commission (MHC) was appointed in August 1997 and the six commissioners were; Mr Wayne McLean (CEO, Raukura Hauora O Tainui and HFA Board Member), Dr Erihana Ryan (Director of Area Mental Health Services for Canterbury), Dr Tony Ruakere (General Practitioner for Te Atiawa Medical Centre, New Plymouth), Mrs Heather Thomson (Manager, Family Service Centre, Opotiki) Mr Rob Cooper (General Manager, Māori Health Division, HFA), and Mr John Broughton (Senior Lecturer, Māori Health, Dunedin School of Medicine and Otago Dental School). The Role of the Māori Health Commission (MHC1998b) was
determined from the directions set down by Cabinet and the Terms of Reference which require the Commission to:

(a) Assist the Government in meeting their Strategic Result Area (8) for 1997 - 2000 by making “significant progress towards the development of policies and processes that lead towards closing the economic and social gaps between Māori and non-Māori.”

(b) Operate as ‘think tanks’ by developing initiatives for accelerating Māori development in education, health, economic development and employment and training that can be grafted onto mainstream.

(c) Assess the general progress of Māori in each policy sector, the implications of monitoring reports of other agencies and reports on the progress of our own initiatives.

(d) Co-ordinate, plan and provide advice to the Minister of Māori Affairs in an interconnected and inter-generational manner.

(e) Manage the expectations of Māori communities, relevant sector agencies and the public.

(f) Provide advice and reports to the Minister of Māori Affairs recommending changes to policies for Māori development that will contribute to a reduction of disparities between Māori and non-Māori.

In essence, the Māori Health Commission was established to provide the Minister of Māori Affairs with an independent stream of contestable advice that would contribute to an improvement in Māori health. The Minister himself said, “The Commissions ... were set up as a means of finding grass root solutions for the inequality in the standards of Māori health”. The Māori Health Commission was to have a life of three years until 31 July 2000. The November 1999 election resulted in a change of government and the new Labour administration wasted no time in disestablishing the Commissions by 24 December 1999. However, before the decommissioning, the
Māori Health Commission was able to ensure that the means and processes for the
development and implementation of a new publicly funded Oranga Niho service was
put firmly in place. This particular initiative will be discussed in Chapter 7.

During his term of office as Minister of Māori Affairs, the Hon. Tau Henare released
an important report, *Progress Towards Closing Social and Economic Gaps Between
Māori and Non-Māori* (Te Puni Kōkiri 1998), detailing a statistical review of current
disparities. This report became colloquially known as *"The Gap Report"*. The
significance of this report was that the new Labour Government of 1999 established a
policy of “Closing the Gaps” and published an updated edition of the report in May
2000. The importance placed on this policy was reflected in the establishment of a
Ministerial Committee which was chaired by the Prime Minister. However, this
Committee became something of a political hot potato as the Opposition, the media
and sections of the New Zealand public saw this Committee as giving special priorities
and advantages to Māori over the rest of the population (Hubbard 2004). As a result of
a not inconsiderable backlash, this Ministerial Committee and the policy was
abandoned and replaced by a new policy of ‘Reducing Inequalities’. The Ministry of
Health was charged with developing a framework and policy for reducing inequalities
in health (Ministry of Health 2002a). The intention was the same but the framework
had changed.

The next major response by government to Māori health was the development of the
New Zealand Health Strategy (King 2000a) which was launched in December 2000.
The Strategy was based on seven principles, the first one being the
“acknowledgement of the special relationship between Māori and the Crown under
the Treaty of Waitangi.”. Under this principle, the Government “recognises that the
Treaty of Waitangi is New Zealand’s founding document” and clearly states its
position to fulfil “its obligations as a Treaty partner”: 71
Central to the Treaty relationship and implementation of Treaty principles is a common understanding that Māori will have an important role in implementing health strategies for Māori and that the Crown and Māori will relate to each other in good faith with mutual respect, co-operation and trust.

The goals and objectives of the strategy include reducing inequalities in health status by ensuring “accessible and appropriate services for Māori”. Māori development in health is another goal aimed at building the capacity of Māori participation in the health sector. The Government also identified 13 priority population health objectives for the Ministry of Health and District Health boards “to focus on for action in the short to medium term”. One of the 13 priorities was to improve oral health.

The New Zealand Health Strategy was followed by He Korowai Oranga, Māori Health Strategy (King and Turia 2002) in November 2002. The government reiterated its commitment “to fulfilling the special relationship between iwi and the Crown under the Treaty of Waitangi” in this document. Underpinning this relationship are the principles of Partnership, Participation and Protection which are “threaded throughout He Korowai Oranga.” The Treaty Principles are described as:

**Partnership:** Working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.

**Participation:** Involving Māori at all levels of the sector, in decision-making, planning, development and delivery of health and disability services.

**Protection:** Working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.
The overall aim of the Māori Health Strategy was whānau ora, the health of the family. A key thread of He Korowai Oranga is rangatiratanga in which government “acknowledges whānau, hapū, iwi and Māori aspirations for rangatiratanga to have control over the direction and shape of their own institutions, communities and development as a people”. Despite the aims and objectives of He Korowai Oranga being more comprehensive than what had ever been previously developed, criticism has been made (National Health Committee 2002) that “in general, Māori health policy development, implementation and monitoring at government agency level has been ad hoc, lacking consistency, co-ordination and specificity.” However, He Korowai Oranga was followed by “Whakatākata, Māori Action Plan 2002-2005 (Ministry of Health 2002b) which details the four pathways (iwi development; Māori participation; effective health and disability services; and working across the sectors) to achieve the goals set out in the Māori Health Strategy.

4.4 The Health Sector Response

In 1986 the Director-General of Health, Dr George Salmond (Department of Health 1986) had articulated his Department’s view of the ‘special significance’ of the Treaty:

Concepts of health are firmly based in Māori culture (which according to the Treaty, has a right to official recognition and protection) and Māori people have a right to appropriate health services – funded through our health system. The department accepts this view which is in accord with the WHO principles set out in the Alma Alta Declaration of 1978 on Primary Health Care.

The previous year, a newly established Standing Committee on Māori Health (Department of Health 1986) with an advisory role to both the Board of Health and
the Minister of Health on Māori health matters stated that “the three Articles of the Treaty of Waitangi be regarded as the foundation for good health in New Zealand.” This was followed by the establishment of a Ministerial Advisory Committee on Māori Health (1990) which was chaired by Dr Mason Durie to assist the Minister of Health, the Hon Helen Clark to address ‘this priority area’. This Committee developed policies for Māori health and guidelines for Area Health Boards based on the three Articles of the Treaty. The Committee recommended that Area Health Board policy on Māori health should be guided by ‘representative Māori opinion’ through consultation with iwi authorities and that local Māori health policy committees should be established to address specific health goals and targets. However, it was not until after the restructuring of the health sector in 1992 that any real effect was able to be given to these policies, beginning with the Regional Health Authorities.

The health sector response to Māori health disparities included the responses by the RHA, HFA and subsequently the District Health Boards (DHB). The Southern RHA (SRHA) in A Year In Review 1993/94 (SRHA 1994) noted that “particular consideration is given to the needs of Māori”. This included the acknowledgement of “Māori aspirations and structures, and the desire of Māori to take responsibility for their own health care”. This was in effect an acknowledgement of rangatiratanga or Māori leadership. This approach was reiterated in He Matariki: A Strategic Plan for Māori Public Health (The Public Health Commission 1995) which noted that “the promotion of oral health delivery and ill-health prevention should involve Māori at all stages. The individual recipients should be empowered to seek preventative strategies and care that is appropriate and effective in maintaining good oral health.” The SRHA subsequently provided some funding for Te Whare Kaitiaki, the Māori oral health clinic based at the University of Otago School of Dentistry.
The SRHA draft Strategic Directions (1996) identified a number of principles which were to guide their “purchasing activities and decisions”. One of these principles was that “the SRHA will meet its obligations under the Treaty of Waitangi”. The SRHA then developed a Māori Health Strategic Plan (SRHA 1997) for the five year period, 1997-2001 with the kaupapa of “Ko te mana hauora; Ko te mana Takata - Good health strengthens the dignity and strength of the people”. The “Vision for 2001” was for “Māori communities to have an increased level of confidence that enables them to assume a greater responsibility for their own health and well being”. Rangatiratanga was seen to be upheld and the three other RHAs developed similar guidelines and strategic plans.

The four RHAs were amalgamated into a single Health Funding Authority (HFA) in 1998 which then developed a Treaty of Waitangi policy (HFA 1998a). This policy required that all contracts “shall demonstrate how the policies and practices of their provider organisation and service delivery shall benefit Māori clientele”. All health providers, including public dental health care services, were therefore required to ensure that Māori needs were adequately addressed. In 1998 the Board of the HFA (HFA 1998b) identified eight priority areas for Māori health gain, one of which was oral health. Funding for these areas was deemed to be a priority. These eight Māori health gain priority areas were also part of the New Zealand Health Strategy and the Māori Health Strategy. However, whilst these strategies, guidelines and principles were all well intentioned, it became evident that the health ‘reforms’ had little impact upon the improvement of Māori oral health in the short term. There was an emphasis on the restructuring of the health sector and management rather than improving the delivery of oral health services. One strategy that was introduced was emergency care available for low income adults but both the eligible client group and the service provided was very limited.
With the advent of the District Health Boards in 2001, each Board throughout the country set up local Māori consultation groups. As a result of this dialogue between the Boards and Māori leaders who were mandated to act and speak on behalf of their communities, hapū and iwi, Memoranda of Understandings (MoU) were developed for each Board. For the Otago DHB a Memorandum of Understanding (Otago DHB 2003 and Memorandum of Understanding 2003) was signed on 13 February 2003 between the local runaka (Kā Papatipu Runaka of Hokonui, Ōtākou, Puketeraki and Moeraki) and Te Pouri Hauora-a-rohe ki Otago (the Otago DHB) in 2003. The MoU was based on four priorities. Priority One was that “the Kāi Tahu Treaty of Waitangi Principles are the foundation on which all negotiation with Crown agencies are based. They establish the rights and obligations under statute of both partners and underpin relationships with Crown Agencies”. Priority Two ensured that “all Treaty partnership agreements with the Crown need to be consistent with Ngāi Tahu 2005 document – its milestones and 25-year outcomes”. Priority Three of the MoU is about relationships which “gives effect to the Treaty Relationship Agreement between Manatu Hauora (HFA agreement 17 August 1999) and Te Rūnanga O Ngāi Tahu. It reinforces the status of mana whenua (ie kā Papatipu Runaka) as the sole Treaty partner of the Otago DHB”. Priority Four was concerned with the process of implementation of objectives. Such a MoU reflects the leadership of Māori for and on behalf of their communities and highlights that the initial point of interaction between the two partners is the Treaty of Waitangi.

Whilst dental health status was not mentioned specifically in the Closing the Gaps reports due to the lack of any recent epidemiological data on adult Māori dental health, the concern was discussed in the Ministry of Health Report, Well Being of Whānau (family) (Ministry of Health 1998b) which noted that “Māori have relatively poor dental health compared to non-Māori.” The National Advisory Committee on Core Health and Disability Services (1992) had recommended that “emphasis should be
placed on ensuring fairness of access to core services.” Dental Services were listed as a core health and disability support service. This recommendation was included in the policy guidelines for Māori health 1996/97 (Shipley 1996) for the four RHAs by the Minister of Health, the Hon Jenny Shipley. These guidelines noted that dental caries in young children was a condition “found more frequently in Māori than in other population groups.” The guidelines also detailed the dental health services that were to be purchased including “essential dental services that are immediately necessary for the treatment of pain and infection for low income adults who are unable to afford to attend a dentist...”

In May 2003 the Public Health Advisory Committee (Thomson et al. 2003) reported to the Minister of Health on strategies to improve child oral health and to reduce child oral health inequalities. The report included the issues surrounding Māori child oral health and recommended that the Minister:

- direct the Ministry of Health to fund evaluation of current Māori oral health initiatives
- requires the Ministry of Health to continue to evaluate and monitor mainstream oral health services for their impact on Māori oral health
- encourages District Health Boards to make further funding available to improve Māori oral health status.

These recommendations are designed to allow for the development and implementation of strategies to improve Māori child oral health. However, for that to occur, there is a requirement on the behalf of individual DHBs for a firm commitment to actually do something. One outcome to date has been the establishment of adolescent oral health coordination groups to improve the uptake of the dental benefit scheme by rangatahi (Māori teenagers)
4.5 The Dental Health Sector Response

The response to Māori oral health within the dental health sector had been largely ignored throughout the first 80 years of the 20th Century. Professor Pickerill (1923) the first Dean of the Otago Dental School had claimed that “the pre-European Māori was of all races the most immune to dental caries.” This is a somewhat spurious claim as there was no sugar in the diet of pre-European Maori thus giving a perception of immunity to caries. A smattering of published papers on aspects of Māori oral health occurred over the following 80 years. These included Pickerill (1914) An investigation into the causes of immunity to dental disease in the Māori of the Urewera; Buck (1925) The Pre-European Diet of the Māori; Saunders et al. (1938) The dental condition and diet of the Māoris of Maungapōhatu Village; Hewat (1953) The dentition of the New Zealand Māori today; Ludwig et. al. (1964) The dental condition of a rural Māori population; and Verboeket (1976) Dental attitudes in a rural Māori population. These papers tended to be descriptive accounts of Māori oral health status in particular communities. There was a noticeable change in the attitudes of the investigators from the paternalism of Saunders who stated that “every possible effort should be made to encourage him to blend the best features of that culture with only the best that the European can offer him,” to Verboeket’s recognition of Māori autonomy by suggesting that “Māori may have an alternative way of looking at dental health.”

It was not until the early 1980’s that the beginnings of a new focus in responding to Māori oral health emerged. Edward (1983) presented a Special Report, Māori Dental Health to the New Zealand Dental Association (NZDA) which set out to underlie and “explain some of the attitudes towards dentistry and the profession and to suggest some practical means of improving the health of Māori people.” The report included an Appendix on “community aspects of dentistry” by an unnamed Māori who had “a
long career in secondary education and the Waiariki Community College.” The kōrero (discussion) outlined in this Appendix was very damning of the dental profession for a lack of a “combined community care for dental health by a Dental Association representing New Zealand Dentists.” This attack was balanced by an extensive list of suggestions and recommendations to improve the situation and respond to the unmet dental health needs of Māori.

The following year Edward (1984) presented a report to the Executive of the New Zealand Dental Association on the Hui Whakaoranga Māori Health Planning Workshop held at the Hoani Waititi Marae, Auckland in March 1984. As a result of the outcomes of this important national hui, Edward put forward the recommendation that “the continued interest and presence of the Dental Association is of the greatest importance to improving dental health for Māori people.” Further recommendations were made regarding a Māori health component of dental undergraduate education, dental services for kōhanga reo and antenatal services.

Whilst these attempts to respond to Māori oral health were recognised by the New Zealand Dental Association, the implementation of any particular strategy had still not occurred. Further recommendations were made by Kaa (1982) Principal Dental Officer to the Tairawhiti Area Health Board, to the Dental Council of New Zealand in 1992. In conjunction with Edward in a paper entitled Māori Community they outlined the two concepts underpinning the Māori approach to oral health care (being the Treaty of Waitangi and tino rangatiratanga).

The response to Māori oral health was now beginning to gain momentum. As a result of the work undertaken over the previous decade a paper was published in the NZDA Journal (Edward 1992) on How the Māori community sees the dental-care system. Edward concluded that many complex factors precluded “the Māori community from
many of the perceived benefits of the present oral health-care system.” He challenged the profession to “re-focus on primary prevention policies that will be relevant to the Māori community of today.” He also noted that “no one is seen in the Māori community to be articulating concern for oral health issues.” Whilst this latter statement may have been quite fair and reasonable, it did not necessarily mean that Māori were not concerned and that oral health programmes for Māori were non-existent. Christchurch dentist Desmond Smith (Christchurch Press 1988) had described oral health promotion activities within the kōhanga reo movement: “In song and in actions the youngsters are being taught the happiness of strong teeth in a healthy body.” He also noted that “a number of the mothers present are getting the message too…” Although the mid to late 1980’s and the early 1990’s had seen the development of a very small number of small-scale oral health services targeted at Māori, Edward was quite right in his assertion that no one was seen in the Māori community to be actively and publicly voicing concerns. That leadership was yet to emerge.

Brown and Treasure (1992) had described inequalities in oral health with Māori children, adolescents and adults being disadvantaged through a lack of access to oral health-care services, along with Pacific peoples and those from the low income group. They concluded that, whilst the seriousness of poor oral health could not be ignored, the challenge would be in overcoming the barriers to dental care.

Thomson (1993) highlighted the association of ethnicity and child dental health in New Zealand by describing the caries experience of a population of 5-year-olds and Form II children (aged 12 or 13) by their ethnic background. This was a very significant publication because, for the first time the fact that “Māori children were three times more likely to have high (five or more missing or filled teeth) caries experience than non-Māori children” became widely promulgated. Thomson’s coup


*De grace* was the statement that “it is unlikely that the dental health outcome differences between Māori and non-Māori children will be reduced by the current dental health care system unless dental health promotion becomes more effective and culturally appropriate.”

Thomson’s paper was published in the NZDA Journal along with a paper by Broughton (1993b), *Te niho waiora me te iwi Māori: dental health and the Māori people*. This was the first publication in the Dental Association’s Journal about Māori oral health by Māori. The two papers in this edition of the Journal were supported by the editorial which stated that “both authors present a message that may be uncomfortable to many in the dental profession and the School Dental Service.” This statement was the impetus for a more concerted response by the dental profession to meet the oral health needs of those currently disadvantaged.

That response came with the New Zealand Dental Association who developed oral health goals for the new millennium in 1999 (NZDA 1999). This report stated that “fundamental to the approach taken is the principles of the Tiriti o Waitangi as central to both Māori health development and a healthier New Zealand.” The NZDA acknowledged Te Tiriti o Waitangi as a ‘living document’ and that “its application is as important today as it was in 1840 and its principles just as befitting in the provision of oral health services.” The Goals document outlines specific oral health goals and targets for Māori throughout life.

In 2002 the National Health Committee (2002) described the five Māori health policy strategies that have been implemented over the last decade as “consultation, participation in the health sector, workforce development, Māori provider development and mainstream enhancement.” These five policy strategies can be applied to Māori oral health development:
4.5.1 Consultation

Consultation with Māori within the health sector has occurred with increasing responsibility over the last decade. It is well established that better health outcomes are more likely to result following appropriate and effective consultation. As far back as 1986 Cabinet (Cabinet minute 1986) had agreed “that Departments should consult with appropriate Māori people on all significant matters affecting the application of the Treaty.” Consultation was viewed by many Māori as being a tokenistic exercise as the ‘consultation process’ was seen to be a Crown agency merely ‘informing’ Māori about a particular issue rather than a full and meaningful two-way interaction. Edward (1983) noted that “one of the criticisms by Māori people is that there has been no consultation over such (dental health) matters, be it fluoridation, or even at the individual level of communicating with a patient in the surgery.” Consultation with Māori is now an accepted part of grant applications to government funding research agencies and Ethics Committees. The Ministry of Health has engaged in consultation with Māori and has ensured Māori are involved in the myriad of sub-committees and health sector reference and expert groups. District Health Boards have also established Māori consultation sub-committees. Recent examples of consultation with Māori regarding oral health has occurred with the Ministry of Health Technical Advisory Group, The Oral Health Forum, Adolescent Oral Health Coordination Group, National Forum on Water Fluoridation, and various DHB Oral Health Advisory Steering Groups which have been set up. The Dental Council of New Zealand noted in their Annual Report (1997) with regard to Māori oral health that “along with many professionals the lay members have been networking to assist with this national concern. It appears that the many individual initiatives are now communicating and combining on a greater scale.”
4.5.2 Participation in the health sector

The Dental Council of New Zealand (DCNZ) has had Māori representation through the appointment of lay members who are Māori. Mrs Colleen Te Tau-Pringle completed two terms on the DCNZ in 2000 and was replaced by Mrs Christine Rimene. Dr Bill Spark (dentist) was appointed in 2002. Dr Albert Kewene has been appointed to the new Dental Council (along with Mrs Vicki Kershaw, current President of the New Zealand Dental Therapists' Association) which will come into effect from 1 July 2004 under the Health Practitioners Competence Assurance Act (2003). Whilst the NZDA has not had any formal Māori representation at national level, Māori dentists have been invited to participate in DCNZ and NZDA workshops and to present at their biennial conferences (Broughton 2000a). Māori representation has also occurred on the Dental Technicians Board for many years and in 2003 there were three Māori, Mrs Inez Kingi, Mrs Riria Handscomb who were lay members and Mr J Broughton from the University of Otago School of Dentistry. The Oral Health Advisory Group (OHAG), instituted in 2001 following the Oral Health Forum at Massey University in May 2000, had Māori participation through Te Ao Mārama, the New Zealand Māori Dental Association. Over the last decade the Ministry of Health, and in its time, the HFA have also sought Māori participation in a number of forum, committees and conferences for the development of dental health strategies.

4.5.3 Workforce development

In 1996, the “active dentist workforce register revealed that, out of a total of 1346 registered dentists, only six were Māori (0.4 per cent of the registered workforce)” (Te Tau-Pringle 1997). The Dental Council of New Zealand (1999) reported that “the proportion of New Zealand Māori dentists in the active workforce increased from 1.3 percent to 2.2 percent in 1997 but declined again to 1.5 per cent in 1998. However, there were concerns about the ethnicity data collected in the dental workforce survey as in 1998 non-responders to the ethnicity question in 1998 were 5.6 per cent of the
total. Thomson (2003) reported that a total of 30 dentists (or 1.9% of the registered dentists with an Annual Practising Certificate) identified themselves as Māori. The increase in the output of dental graduates from the University of Otago School of Dentistry has occurred despite the escalation in dental student fees since 1995. The number of students who identified as Māori who graduated from Dental School (University of Otago 1996 – 2003) are: 1996: 2; 1997: 1; 1999: 5; 2000: 4; 2001: 3; 2003: 6; 2004: 5; and 2005: 2. In 2006 there are at least 20 Māori undergraduate and 4 postgraduate dental students at the University of Otago School of Dentistry.

4.5.4 Māori provider development

The Māori Provider Development Scheme (MPDS), (HFA 1998c) was instituted in the late 1990s during the lifetime of the Health Funding Authority. It was part of the Government’s commitment to improving Māori health through firstly, enhancing the ability of Māori providers to deliver effective health services; secondly, enabling sustained growth of a skilled Māori health and disability workforce; and thirdly, improving integration and overall co-ordination of health services to Māori. The application for funding guidelines were aligned to the then Health Funding Authority priorities (including the health specific priority of oral health). Although all three Māori oral health providers in this review had made application for funding to this scheme at some time in their development none were successful. The reason given to Te Whare Kaitiaki dentist⁴ was that the number of applications far exceeded the available funding resulting in a strict prioritisation of immediate needs throughout the sector.

⁴ Personal communication, MPDS administrator, Health Funding Authority, 1998.
4.5.5 Mainstream enhancement

Prior to 1990, enhancement of mainstream services with regard to Māori oral health had been virtually nonexistent, apart from two significant developments at the University of Otago School of Dentistry and by the School Dental Service in some areas of the country. The inclusion of Māori oral health as part of the dental undergraduate training at the University of Otago School of Dentistry can be regarded as an example of mainstream enhancement. A module of Māori oral health was developed for final year students in the then Department of Community Dental Health. Whilst there had been a single lecture on the topic by a guest lecturer since the early 1970s (at the instigation of Dr R. H. Brown) it was not until 1990 and the appointment of a full-time lecturer in Māori health at the Dunedin School of Medicine that an extensive module in Māori oral health was introduced. This comprised a total of four 3-hour sessions over four consecutive weeks. The University of Otago School of Dentistry saw it as important that undergraduate dental students were exposed to the issues of Māori oral health, cultural issues in dental health service delivery, oral health promotion targeted at Māori, Māori participation in health service delivery and the Treaty of Waitangi and the New Zealand health sector. This was a major advance in the education of dentists with an understanding of Māori oral health issues and to be able to confidently engage with Māori patients, their whānau and communities. The establishment of Te Whare Kaitiaki, a clinic for Māori and their whānau within the University of Otago School of Dentistry in 1990, is also an example of mainstream enhancement.

Within the School Dental Service, the development of Māori oral health educators and the access to kōhanga reo by school dental therapists providing dental treatment and promotion has also occurred. Other strategies have included the development of Māori oral health resources which have been made available to school dental therapists that have been developed by Māori.
4.6 The Māori Response

The Māori response to improve and maintain oral health has been a three-fold approach. The first is through the constant desire on the part of Māori to develop appropriate and accessible dental health services. The second approach has been through the development of a wide range of oral health promotion and preventive strategies. Both these approaches have been fraught with difficulty as the specifications for publicly funded dental care is very rigid and often outside the needs that have been identified by Māori. The third approach has been the establishment of a national Māori health organisation totally dedicated to Māori oral health (Te Ao Mārama, the New Zealand Māori Dental Association).

4.6.1 Māori Oral Health Services

In an effort to overcome poor oral health care, Māori people have been pursuing the development of appropriate, accessible and affordable dental services. Those few services that have been developed have not occurred without difficulties and seemingly insurmountable barriers to circumvent. They are all quite unique as they have developed as a response to local Māori social infra-structures, existing health services and the commitment of the people involved. As such, they are all quite different; no two services are the same although they all have the same desired outcome, an affordable and effective oral health service. Two Māori providers that were able to provide some oral health services in the early 1990s were Te Whānau o Waipareira Trust in West Auckland and Ngāti Hine Hauora Whānui at Rāwene, Northland. The University of Otago School of Dentistry in Dunedin established a dental clinic for Māori as a result of Māori initiative. Māori oral health services are still in their infancy and are a high priority on Māori health provider ‘wish lists’ for development. Accounts of Māori oral health service development are presented in Chapter 6 and Chapter 7.
4.6.2 Māori Oral Health Education

The second approach was the development of culturally appropriate oral health education resources and preventive strategies by Māori for Māori. Prior to 1990, there were virtually no Māori specific oral health education resources. In 1990 the NZDA had a brochure about dental services translated into te reo Māori (Māori language) but this had a limited distribution and life. From 1998 onwards, there has been a small but significant increase in the production and dissemination of oranga niho resources by Māori providers and Crown Public Health agencies. These are documented in Chapter 12.

4.6.3 Te Ao Mārama, The New Zealand Māori Dental Association

Te Ao Mārama, (the New Zealand Māori Dental Association) was established in 1995 at the first national Māori hui for oranga niho held at Ōhinemutu, Rotorua. The kaupapa of the new organization was, Hei oranga niho mō te iwi Māori (Oral health for Māori). At the second national hui 12 months later, the objectives and constitution of the new organization were ratified by the membership (Broughton 1997). The objectives were to:

1. uphold Māori oral health as guaranteed under Te Tiriti o Waitangi;
2. pursue the delivery of oral health services to Māori at the optimum level;
3. safeguard and promote the oral health of te iwi Māori; and
4. promote the opportunity for te iwi Māori to access quality oral health services.

The constitution stated (Te Ao Mārama 1997a):

Membership shall be open to Māori school dental therapists, Māori dental surgeons, Māori dental specialists, Māori dental hygienists, Māori dental
technicians, Māori dental assistants, Māori dental administrators, Māori students of dental science, Māori health community workers, Māori health researchers, other Māori health professionals and Māori people committed to hauora niho. Membership shall also be open to other health professionals who have been nominated and approved by two thirds majority, for membership at the Annual General Meeting of Te Ao Mārama.

Te Ao Mārama has played an effective role in highlighting the need for government agency action to develop and implement strategies to reduce the oral health disparities that exist between Māori and non-Māori. This was reflected in the Board of the HFA (1998b) including oral health as one of the eight Māori health gain priority areas. Te Ao Mārama (in conjunction with the Māori Health Commission) was also responsible for developing the Māori goals for Oral Health in the New Zealand Dental Association’s document *Oral Health Goals for all New Zealanders for the New Millennium*. The impact of these strategies was to raise the awareness of oral health with government agencies, Māori health providers and Māori communities. Te Ao Mārama serves as an important Māori organisation to foster and promote oranga niho among Māori for the dissemination of information and new developments and services in oranga niho and to foster professional support and whanaungatanga among its membership. This national organisation, which has been recognised to represent the Māori view of oral health, is an assertion of Article II of the Treaty of Waitangi, and is a classic example of tino rangatiratanga. It is a recognised leader for Māori oral health.

4.7 *Te Whakamutunga* (The Conclusion)

There are a number of important strategies which have been developed to improve the unmet dental disease of Māori. Operating at different levels the response by
government, the health sector, the dental health sector and Māori has resulted in concerted attempts to meet the challenges. Some would argue that little has been achieved to date. Supporting this contention are the disturbing and widening disparities in health and dental health status between Māori and non-Māori. However, what has been achieved is the laying down of the groundwork, pathways and processes for the development of appropriate and accessible oral health services for Māori. In looking at the developments over the two decades of the 1980s and 1990s, the over-arching theme has been tino rangatiratanga or self-determination. This was the basis of Article II of the Treaty of Waitangi which established a recognition of the sovereignty of Māori leadership. Māori therefore have the legitimate expectation that they should have control, ownership and responsibility for their own oral health care and services. The achievements that have occurred up to the present time are the result of a strong Māori leadership in oranga niho and the acknowledgement of that leadership by government agencies, the health sector and the dental health sector. The emerging Māori leadership in oral health is the key strategy for the development of Māori oral health services.
Chapter 5

Whakakotahitanga

(Unity)

5.1 Te Kōrero Tuatahi (Introduction)

Whakakotahitanga is the concept of unity, in which a collective has been established through the interconnection of particular commonalities thus forming a complex whole or oneness. For Māori, as for many cultures, this concept of unity functions at a variety of levels within the social fabric of their society. Membership of a whānau is based on a birthright that unites those family members. Likewise hapū (sub-tribe) and iwi (tribe) have a bond between members that unites them together through kinship ties. This gives rise to strong feelings of unity and a sense of belonging which is central to the Māori psyche. The notions of unity are epitomised in the whakataukī or proverbial saying, Ma te kotahitanga e whai kaha ai ti teu (In unity we have strength). The Hon. Tariana Turia¹ describes kotahitanga as, “unity of thought and unity of purpose”. An element of Whakakotahitanga is holism, a widespread view of interconnectedness. This gives rise to the notion of a holistic view or a holistic belief or beliefs. The Māori concept of health and wellbeing is often described as being holistic.

There are a number of models of Māori health and wellbeing which are based on biological, psychological, social and spiritual constructs. They include Te Whare Tapa Whā (The house of four walls) described by Durie (1998), Te Wheke (the octopus or squid) described by Pere (1984), and Ngā Pou Mana (the prestigious carved posts) as outlined in the Royal Commission on Social Policy (1988a). The three models are in effect very similar with the single real difference being the manner in which they are

described. They all uphold the notion of an ‘holistic’ approach to health. This in turn is an application of Whakakotahitanga, in that to have and maintain good health and wellbeing necessitates all contributing aspects to be sound, secure and functional.

5.2 Te Whare Tapa Whā

Te Whare Tapa Whā compares health to the four walls of a house. Durie (1998) described how it was first elucidated and documented at a hui for the Māori Women’s Welfare League’s Rauora Study in 1982. It was discussed at length at the Hui Whakaoranga, the Māori Health Planning Workshop (Department of Health 1984) at Hoani Waititi Marae in March 1984 and since then has received virtually universal acceptance by Māori. Ngata and Dyall (1984) describe the model as being the foundations of health for Māori that embodies a holistic philosophy encompassing spiritual, mental, family and physical dimensions. Each dimension cannot be looked at separately but are all inter-related to form a whole. Durie (1985) provides a more detailed explanation describing it as a “four-sided concept representing four basic tenets of life. There is a spiritual component, a psychic component, a bodily component and a family component.” Ropiha (1994) supports this Māori approach with the argument that “Western medicine tends to emphasise bodily health at the expense of those functions which could not be explained by the laws of physics. In contrast, Māori theories of health minimised mechanistic forces in favour of strong influences of mental attitudes and supernatural powers.” The Māori concept of health is much wider than that of physical well being; it embraces other dimensions of a person’s existence. Māori therefore have an integrated view of health based on four cornerstones. The Public Health Commission (1995) defined these cornerstones as:

Te taha wairua as the spiritual health of whānau, includes the practice of tikanga

Māori in general, and therefore the ways in which health services are delivered.
Te taha hinengaro refers to the mental wellbeing of the whānau as well as the mental health of each individual within it.

Te taha whānau refers to the whānau environment in which individuals live. It includes the cohesiveness of the whānau unit, the health of the environment created within the whānau (for example, whether it is safe and supportive), and the relationship of the whānau to its community.

Te taha tinana refers to the physical aspects of health as well as the physical symptoms of ill-health.

The basic descriptions of Te Whare Tapa Whā have been drawn in the main from the accounts by Durie and Ngata. Where appropriate the discussion which follows has been extended by the addition of a Māori oral health dimension.

Māori people believe that the mind, body and soul are all closely inter-related and influence one's physical state of well-being. Physical health cannot be dealt with in isolation nor can the individual person be seen as separate from one's family. These four dimensions of health cannot be separated but instead are inter-related to form an integrated whole. All four elements together are essential for good health and well being. This holistic view of health is also important in understanding the Māori at the time of the coming of the European and all the disruptions that a new culture brings. For if we go back to our model of a house, or if one wall becomes unstable, or one wall is taken away, then the whole house collapses. What follows can be a host of not only physical health issues but also psychological and socio-economic issues.

5.2.1 Te taha wairua (The Spiritual Dimension)

The spiritual aspect of an individual is unique to that person. The wairua is that life force that determines who you are, reflecting where you have come from and provides
guidance to the future influenced by your ancestors. Māori people in everyday life acknowledge and respect the presence of ancestors by the observance of particular beliefs and cultural practices. Māori tribal histories and folk lore provide the links between the cosmological world of the gods and the present time. One particular story with a dental component comes from Ngāi Tahu (1997) of the South Island:

Foveaux Strait is known as Te Ara a Kiwa (the pathway of Kiwa), the name relating to the time when Kiwa became tired of having to cross the land isthmus which then joined Murihiku (Southland) with Rakiura (Stewart Island). Kiwa requested the obedient Kewa (whale) to chew through the isthmus and create a waterway so Kiwa could cross to and fro by waka. This Kewa did, and the crumbs that fell from his mouth are the islands in the Foveaux Strait, Solander Island being Te Niho a Kewa, a loose tooth that fell from the mouth of Kewa.

Contemporary Māori belief systems of spirituality encompass pre-European beliefs of cosmology, supernatural forces and a 'supreme being'. Māori uphold links to atua (supernatural being) from te ao tawhito, (the pre-European Māori World) including Rangi-nui (The Sky Father) and Papa-tū-ā-nuku, (The Earth Mother) the primeval parents of the universe, and ‘Departmental Gods’ or ‘demi-Gods’ such as Tāne-mahuta (God of the Forest), Tangaroa (God of the Sea), Rongo (God of Peace), Tū-mata-uenga (God of War), Tāwhiri-mātea (God of the Winds) and Haumia-tiketike (God of the Fern Root). The spiritual dimension also encompasses beliefs in wairua (spirit), which may be regarded as the equivalent of the immortal Christian soul of a person, kōhua (ghosts), tūpuna (ancestors), kaitiaki (guardians), taniwha (monsters), mana (power and authority), tapu (protective rites, sacred and forbidden), karakia (prayers and/or incantations), and tohunga (specialists, spiritual protectors). At the same time Māori are strong adherents to Christianity which was first introduced initially by missionaries from the Anglican Church Missionary Society in 1814. At the 2001 Census, 98 percent of people of Māori
ethnicity who stated a religious affiliation were Christian. The main Christian
denominations were Anglican, Catholic and Rātana. The contemporary Māori has no
problem in embracing both Māori cultural beliefs of spirituality and Christian beliefs at
one and the same time. To Māori they are not mutually exclusive but quite the opposite;
they are complementary, one belief system supports and reinforces the other.

Before the coming of the Pākehā and Christianity, Māori religion dominated and was a
reflection of the Māori way of life. There were prayers, incantations and karakia for all
aspects of life and work. The tohunga who was a very tapu person, was, and remains the
protector of all things spiritual. Thus the spiritual realm, the realm of the gods, was very
much a part of everyday life. That is, the physical realm was very much immersed in
and integrated with the spiritual realm. That same acknowledgement is still recognised
today. For Māori, every act and physical phenomenon is considered to have both
physical and spiritual implications: supernatural forces govern and influence the way
people interact with each other and relate to their environment.

5.2.1.1 Tapu

An important aspect of te taha wairua is the concept of tapu. There is no one-word direct
translation of the word, ‘tapu’; it is a complex concept with a range of meanings
de pending upon the context in which it is used. In general ‘tapu’ refers to the notion of
being set apart (Mead 2003). Barlow (1991) states that “first and foremost tapu is the
power and influence of the gods.” Shirres (1997) provides a detailed account of the
complex nature of tapu making a distinction between ‘intrinsic tapu’ and ‘extensions of
tapu’. Intrinsic tapu, of the human person for example, exists when they receive their
‘being’ and therefore their intrinsic tapu from spiritual powers. Shirres points out that
“in this universe ,, in which everything has its own tapu, there is a constant meeting of
tapu with tapu.” Therefore, to ensure that there is control and order in the meeting of
tapu with tapu, a system of restrictions has been devised which Shirres refers to as
‘Extensions of *tapu*. Shirres states that “there are many restrictions surrounding the human person. To respect the *tapu* of the person there are *tapu* days, *tapu* places, *tapu* hands, *tapu* food, *tapu* fields, and there are *tapu* events, especially birth, hair-cutting, warfare and death.”

In simplistic terms *tapu* may be thought of as being ‘sacred’ or ‘religious’, but it is much more than this (Durie 1977). *Tapu*, generally applies to a person, place, event or object that has been set apart for some particular reason, as opposed to being noa (commonness or free of *tapu*). The social world of the Māori was, and still is today, governed by the lore/law of *tapu* as it regulates what a person can or cannot do in certain circumstances. Any transgression of *tapu* may lead to a withdrawal of divine protection, making one vulnerable to spiritual illness. Violations of *tapu* include interference with *tapu* objects, *tapu* places or the *tapu* of people. The infringement of the lore/law of *tapu* as a cause of illness and death is still implicitly believed by many Māori people today (Durie 1977, Durie 1998, Ngata, 1987).

### 5.2.1.2 Te ao tawhito

The understanding of the mouth and teeth was explained in terms of the cosmological beliefs and spiritual beliefs of *te ao tawhito* (pre-European Māori society). There was a strong belief system in supernatural forces which emanated from *atua* (supernatural being) which imposed lore, behaviours, and cultural practices. These concepts and their application to dentistry were presented at two *hui* in which oral health from a Māori spiritual viewpoint was discussed. The two *hui* were the First National Hui Oranga Niho (Te Ao Mārama 1996) at Ōhinemutu in 1996 and the Māori Oral Health Hui hosted by the Ministry of Health (Ministry of Health 1999) in Wellington in 1998. From the *korero* (discussions) at both *hui* a picture of Māori oral health emerged based on *ngā taonga tuku iho o ngā mātua tūpuna* (the treasures (knowledge) handed down from one’s ancestors). The following account was derived from those two *hui.*
5.2.1.3 The cosmology of Māori oral health

Teeth and the oral cavity were just as important in pre-European Māori culture as anything else and featured very vividly throughout the culture. Oral health was an important part of overall health and wellbeing. It was not only regarded as being a vital part of *te tinana* (the physical body) but there were clear associations with *wairuatanga* (spirituality). In the Māori belief system of the creation of the universe, the world and people, Tāne-mahuta was responsible for the creation of human beings. He made the shape of a woman out of the red earth and breathed life into her with the expression, "*Tihei Mauri Ora!*" (Behold the breath of life!) and so was born Hine-ahu-one, the Earth Formed Maid. *Te hā* (the breath) emanating from *te waha* (the mouth) originally came from *atua* (supernatural being) and was therefore in a state of purity and absolute health. As a result *te upoko* (the head) including the mouth was, is, and remains very *tapu*.

*Te waha* (the mouth) can be seen as being made up of time (*wā*) and breath (*hā*) which, when combined, allude to the original breath of life, ‘*Tihei Mauri Ora*’. *Te waha* is the repository of *te reo* (language, spoken word) and the mouth is therefore the vehicle for oral expression through *karanga* (call), *whaikōrero* (oratory), *waiata* (song), *haka* (dance), and *whakapapa* (reciting genealogy). The mouth is regarded as the entrance way or portal to *te tinana* (the body) and becomes ‘*te waha o te whare tūpuna*’ (the entrance of the ancestral house). A link is therefore made with the spiritual dimension. Standing as guardians at the entrance are *ngā niho* (the teeth). The teeth are regarded as the *kaitiaki* or guardians of the body as what goes in is *kai* (food) and *wai* (water), the necessities for nourishment and life, and what comes out is *te reo* (language) and *kōrero* (speech) reflecting communication of inner thoughts and ideas, proclamations, instruction, and knowledge through the spoken word.

There was a distinct terminology for the anatomy of the mouth and teeth:

<table>
<thead>
<tr>
<th>niho</th>
<th>tooth</th>
</tr>
</thead>
<tbody>
<tr>
<td>niho tapahi</td>
<td>front tooth, incisor</td>
</tr>
</tbody>
</table>
Williams (1971) translates the word ‘kauae’ to mean ‘jaw’, ‘chin’ and ‘tattoo marks on the chin’ as well as other meanings. The term ‘kauae raro’ which can refer to the lower jaw or mandible also means ‘lore of things terrestrial’. Likewise, the term ‘kauae runga’ which can refer to the upper jaw or maxilla also means ‘lore of things celestial’. These connotations indicate the spiritual significance of the mouth. ‘Te arero’ which is the tongue is also the name for the upper point of a taiaha (a weapon similar to a quarter staff) which is carved in imitation of a human tongue.

Māori culture is regarded as an oral culture with the transmission of mātauranga (knowledge) occurring through the spoken word. Hence whaikōrero (formal speech), whakapapa (genealogy), waiata (song) and karanga (formal call) were central to education, learning, expression and communication of histories, belief systems and knowledge of cultural practices. The skill of oratory was the use of analogy, metaphor...
and story telling. Whakatauākī or proverbial sayings were an important part of oratory, and the oral histories of Māori feature many examples using the teeth or oral cavity. For example, He rei ngā niho, he paraoa ngā kauae, would translate as, “A whale’s tooth in a whale’s jaw” (Brougham and Reed 1987). What this in effect means is, if you have a whale’s tooth, you must have a whale’s jaw to hold it. This is a metaphorical referral to the notion that one must be the right person for a particular job.

An examination of toi Māori (traditional Māori visual arts) and kapa haka (Māori performing arts) reveals a particular emphasis on the oral cavity. In whakairo (carving) with a generally abstract representation of the human form, the mouth, lips and tongue are often depicted in an exaggerated form. The mouth and lips may be excessively out of proportion to the size of the face coupled with a very large protruding tongue. The mouth may become the focal point of the whole carved figure which signifies the importance of the mouth and teeth. ‘Nihotaniwha’ which may be translated to mean ‘sharks tooth’ is a traditional design in raranga (weaving) and tukutuku (woven wall panels). The haka, the traditional posture dance of shouted poetry and accompanying actions emphasises facial expressions including the protrusion of the tongue. Broughton and Rimene (1998) described the haka is “an unashamedly male phallic ritual.” Kāretu (1993) provides a very forthright explanation:

The tongue is the avenue whereby the thoughts of the mind are conveyed to the audience. It is, therefore, correct that the tongue should be so honoured as it is in carving of male ancestors. Within my own tribal area, Tūhoe, I have heard the following philosophy expounded in seminars where elders debated issues of tradition and culture at great length. The male has his penis to prove his manhood; it is an appendage that is visible. This, then, is the reason that the male
extends his tongue full length for it then becomes the symbol of his penis, of his manhood, during the dance.

5.2.1.4 *Niho tunga* (Toothache)

The pre-European Māori explanation of the causation of sickness and even death was a spiritual belief in that the body was infected by a malignant spirit due to some infringement of *tapu* by the infected individual. The cure was therefore a spiritual cure effected by *tohunga* who sought to drive out the infection through *karakia* and purification rites to bring about a spiritual cleansing. Although the Māori of *te ao tawhito* suffered from oral disease there was very little actual dental decay. Professor Pickerill (1923), the first Dean of the University of Otago Dental School, described the pre-European Māori as “being the race most immune to dental caries”. However, the Māori of old did suffer the pains of toothache and periodontal disease was rife. Buck (1910) stated that “toothache was supposed to be caused by the gnawing of the ‘tunga’ grub as it attacked the fang of a tooth.” Williams (1971) states that the name ‘tunga’ is “given to the larva of *Prionoplus reticularis*, a grub found in decayed wood”. The name is also used for both a decayed tooth and toothache. Williams lists other notations for toothache as “tunga raupapa” and “he niho tunga”, the latter translating as “decayed, aching of a tooth.” Riley (1994) suggested that, “it is quite possible that the nerve of a tooth resembles a larva.” The tooth was believed therefore to be infected by a ‘tooth worm’. Richard Taylor (described by Gluckman 1976) a missionary to New Zealand in 1846 was also “an accomplished extractor of teeth”. He had recorded how following the extraction of a tooth his Māori patient would break it open to see if there was a worm inside. Gluckman commented that “even today it is not rare to find Māoris (sic) who believe tooth ache is due to a grub in a tooth.”

Attrition of the occlusal surfaces of the teeth occurred due to the abrasive nature of a *kai moana* (sea food) diet through the contamination of sea food by sand and through the
chewing of fibrous food, especially arehu (fernroot), a staple food. The cause of toothache was therefore likely to be due to pulpitis as an outcome of attrition, exposed dentine and exposure of the pulp. Broughton and Nepia (1999) reviewed dental treatment in the pre-European world of the Māori. There were a variety of remedies and cures for toothache which were extensively documented by Riley (994) who noted that karakia (incantations) specifically for tooth ache were “sometimes in the form of a plea to the tunga”:

A decayed tooth,
a sharp-edged broken one,
etirely broken, entirely hollow,
will you eat up entirely the head of the damaged point?

The grub had to be persuaded to leave:

Go you, who bites man.
You who cuts and lacerates.
As mist is to the cloud.
As cooking is to the oven.
Act, ancestor Manu i te rā,
Eat the long tap root,
The long worm.
Move, ancestor Tuhunga,
Get rid of the grub.

Sometimes a hollow rush was placed against the tooth to provide an extra path for the grub. In another karakia documented by Riley the obvious question is posed:

What is your ailment?
Is it the toothache?

If the answer was yes, then the following *karakia* was recited:

*Lance amidst the foreign demons and into the annoying pain,*

*The pain which gnaws.*

*Destroy the pain inside and outside,*

*It is evil, it is foreign that which attacks you.*

*Go to the sea from which you originated,*

*Sickness comes,*

*Wellbeing follows.*

*Wellbeing prevails, it prevails within,*

*It is the sustenance of life,*

*Oh great life.*

In addition to *karakia*, Riley documents various forms of treatment practices that were also used. These included:

The placement of one end of a small stick against the sore tooth and to tap the other end sharply with a second stick.

This may well have been an early form of pulp therapy.

A magical remedy for toothache was to bite the head off a lizard that had been placed across the decaying molar. Its blood was let run into the hole; this was said to be an infallible cure. The lizard had to be caught by another person who should not let the sufferer see it.
A piece of the long tough leathery cocoon of a kind of caterpillar found hanging from the branches of the manuka shrub was placed on the sore tooth.

Waving a mussel shell before the face was said to exorcise the "tunga grub."

To urinate into a shell, then hold the urine in the mouth for some time, before spitting it out. This had to be done early in the morning to be most effective.

Tohunga were claimed to be expert at both extracting teeth and placing medicaments to deaden the pain. When a tooth was extracted it was immediately broken up to see if it contained a grub or worm.

Traditional Māori healing which includes the use of rongoā or Māori herbal medicine is regarded as part of te taha wairua, the spiritual dimension. Native plants used in the extensive ‘pharmacopeia’ of Māori herbal medicine were all regarded as ngā tamariki o Tāne (the children of Tāne, God of the Forest) and have deep spiritual connotations. The tohunga (expert) held the mātauranga (knowledge) regarding rongoā (herbal medicine), and guarded and protected this aspect of healing very closely. The pre-European Māori indulged in chewing gums which according to Riley “helped freshen the breath”. There were a number of plants such as pōhata, pūwhā, rangiora, taramea, tarata and wharangi which provided a gum or other substance to chew for bad breath. Kauri gum was chewed to cleanse the teeth, while pūwhā gum was credited with both cleansing the teeth and treating sore gums and pimples in the mouth.
There are a number of aspects of the spiritual dimension that are applicable to modern dentistry.

### 5.2.1.5 Tūpuna (Ancestors)

*Tūpuna* are a vital element of Māori culture as *whakapapa* (genealogy) determines an individual’s identity through their *whānau*, *hapū* and *iwi* links with their ancestors. Meeting houses are often referred to as a ‘*whare tūpuna*’ or ancestral house carrying the name of an actual ancestor. Ancestors are regarded as ‘living ancestors’ who may be called upon for spiritual guidance, support and assistance, especially at times of crisis. Attending a dental clinic for treatment can be seen by some Māori as being a ‘crisis’ situation and they may call upon their ancestors for support and solace. I have noted that the American maxim, “Don’t worry, be happy” has been restated by Māori as, “Don’t worry, you have your ancestors with you.” This is a frequently used mechanism for overcoming the perceived fears of dental treatment.

### 5.2.1.6 Kaitiaki (Guardians)

*Kaitiaki* or guardians are spiritual beings who provide a protective influence. *Kaitiakitanga* is a protective or guardianship role over a particular area which may include *whenua* (land) or *moana* (ocean). A dental health clinic targeting Māori at the University of Otago Dental School was given the name *Te Whare Kaitiaki* by local *kaumātua* as it was seen as ‘a place of caring’.

### 5.2.1.7 Taniwha (Mythical creatures)

*Taniwha* are mythical creatures which inhabit oceans, rivers, and waterways and may have protective or guardianship roles as well as instilling fear and dread. Broughton (1992) once referred to the school dental therapist as “a great white starched *taniwha*” which apparently stemmed from the white starched uniform worn by the dental therapist.
including a head-dress with a long remnant hanging down the back like a monster's tail.

5.2.1.8 Kēhua (Ghosts)

Kēhua or ghosts are often associated with the dead and are believed to appear at night out of the dark. The concept of the 'Murder House' became the perception of the school dental clinic for generations of New Zealand children. The Murder House was perceived to be populated by a white robed kēhua that lurked within. Māori have a strong belief in dreams which may include the visitation of spirits of the ancestors bringing omens or warnings of some impending calamity. One kaumātua recalled that:

I do have a recurring dream. When I dream of a set of broken dentures I know that some one is going to die. My ancestors are telling me that; it is their way of telling me. And sure enough it happens every time. Needless to say it is not a happy time for me the next day when I have had that dream.

5.2.1.9 Tohunga (Spiritual protector)

Tohunga translates as 'skilled person' (Williams 1971) or 'expert' (Ryan 1974). Today a tohunga is regarded as the protector of all things spiritual within the context of Māori culture and society. Ryan (1974) translates the word "dentist" into Māori as "tohunga niho" or "tooth expert".

5.2.1.10 Wairua (Spirit)

'Wairua' can be translated to mean 'spirit' (Williams 1971). All living things are said to have a wairua. A particular place can also be said to have a wairua which is a warm,

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2 Personal communication, te whaea (personal family member, mother).
welcoming, non-threatening peaceful atmosphere. The *wairua* of a particular place or setting is something that cannot be seen; it is felt. It may be reflected in the physical surroundings and the people who are there. Māori, like many others, often talk about the ‘vibes’, particularly the ‘good vibes’ which is a way of referring to the *wairua* of a place. For Māori the key element of such positive subjective feelings are *tikanga Māori* (Māori custom) and *kaupapa Māori* (Māori philosophy) which a health provider may subscribe to and practice. The elements which generate positive feelings are *manaakitanga* (caring, sharing, respect and hospitality); *āwhinatanga* (assistance, to relieve to embrace); *aroha* (love in the sense of caring and sharing); *tautoko* (support) and *whanaungatanga* (relationships).

*Tapu* has divine origins that provide lore and law as to what a person can and cannot do in certain circumstances. There is a strong belief in the *tapu* of the body which has important implications in clinical situations, especially with regard to the head. These aspects are discussed in the section on *te taha tinana*.

Spiritual wellbeing is very important for Māori people and is acknowledged in their everyday lives by observing certain behavioural practices. The Māori are a very spiritual people and carry this dimension around with them at all times. It does have clinical implications for dental treatment for many Māori.

### 5.2.2 Te taha hinengaro (The mental dimension)

*Te taha hinengaro* is the mental and emotional dimension of a person. Māori people believe that the mind cannot be separated from either the body or the soul. Māori theory has always been that general health was strongly affected by mental activities. Self esteem is a part of mental health and well being. Poor oral health can have a serious impact upon how one feels about oneself and how one presents oneself to the world.
The toothpaste manufacturers have made strong associations between tooth brushing, oral health and self esteem in their advertising campaigns. Two examples which became well recognised iconic catchphrases in their time are the slogans, “the Colgate ring of confidence” and “She’s got it! He sees it! Macleans did it!” At the oral health project at Rātana Pā (Broughton 1995a) the impact of poor oral health on self esteem was very evident. A number of young Māori mothers with poor oral health tended to hide their teeth when speaking and often spoke with a hand over their mouth, especially to strangers. After one such patient had all her upper anterior teeth restored, her five year-old son came running out to the Māori health community worker saying, “Hey Aunty, come and look at mum! She’s smiling, she’s laughing! She’s got nice new shiny white teeth!” The Māori health community worker commented that the effect on the self esteem of this young mother was considerable. It was the first time that this child had seen his mother smile for such a long time. The grandparent commenting on the response of her daughter following dental treatment said, “She just can’t believe the difference. She’s a whole new person” (Broughton 1995b).

A relationship between mental health and oral health was evident in the comments from Māori mental health workers that I had the fortune to interact with during the course of my work3. One mental health worker who was seeking oral health care for tangata whaiora (Māori mental health patients) in her care said:

In my experience, when one of our tangata whaiora gets a toothache, well everything goes out the window. They go off their medication. They go right off everything. The only dental services in our area are in private practice and our people can’t afford that. For our people in this situation, well it becomes so difficult to manage.

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3 J. Broughton. Clinical experience.
Another Māori mental health worker\textsuperscript{a} related how:

One of our tangata whaora got such a bad toothache that he just took off and ended up going down the street and bopping somebody. The police were called in and he ended up being arrested. And all this happened because we couldn’t get proper dental care.

One Māori mental health worker who brought a tangata whaora to Te Whare Kaitiaki at the University of Otago Dental School commented\textsuperscript{b}:

This is just a part of your healing. We will get your teeth fixed up so that your whole tinana is right. Hinengaro and tinana go hand-in-hand. Holistic health...it’s what we do.

There are a number of concepts that are central to the mental dimension for Māori. They are: the concept of mana which can be very important in the maintenance of mental health; the concept of whakamā which is a state of mind and the behaviour associated with it (encompassing such things as shyness, shame, embarrassment or even anger); and the concept of Māori cultural identity (who you are as a Māori person).

5.2.2.1 Mana

Mana is often regarded as status, prestige or standing. For Māori it is more than this. Mana is power and authority and the origins of that mana. Barlow (1991) states that “mana is the enduring, indestructible power of the gods...in modern times the term mana has taken on various meanings, including the power of supernatural beings, the power of ancestors, the power of the land, and the power of the individual.” Williams (1971)

\textsuperscript{a} J. Broughton. Clinical experience
\textsuperscript{b} J. Broughton. Clinical experience.
provides a range of meanings including “authority, control”, “influence, prestige, power”, “psychic force”, and “authoritative”. Shirres (1997) described how mana and tapu are closely linked: “where tapu is the potentiality for power, mana is the actual power, the power itself.” Mana is the ‘actualization’ of the tapu of the person which has three origins; firstly, mana tangata (power from the people); secondly, mana whenua (power from the land); and thirdly, mana atua (power from our link with spiritual powers). Mana is a quality which cannot be generated for oneself; neither can it be possessed for oneself, rather mana is generated by others and is bestowed upon both individuals and groups (Royal Commission on Social Policy 1988a). Mead (2003) relates how “personal relationships are always mediated and guided by the high value placed upon mana. Mana has to do with the place of the individual in the social group. Some individuals are regarded as having a high level of mana and others varying levels.” The important point in Mead’s analysis is that people of mana draw their prestige and power from their ancestors (referred to as mana tūpuna).

The concept of mana has important clinical applications today. In a modern clinical setting the dental practitioner treats the patient with dignity and respect. Māori describe this aspect of best practice as ‘upholding the mana of the patient’. Health professionals may be regarded as having ‘mana tangata’, which is mana that is given to an individual by others through a recognition of their esteem, their authority and their standing. This is a Māori way of having the utmost trust in their doctor or dentist. A Māori patient once paid a compliment to his dentist by saying, “I place my mana in his hands.”

5.2.2.2 Whakamā

Metge (1986) has given a very full account of whakamā from which this discussion has largely been drawn. Whakamā is a state of mind, a feeling, and the behaviour associated

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6 J. Broughton. Clinical experience.
with it. The extent of the condition can be from mild to severe. There is no one word in English that describes this concept, but it includes such things as shyness, shame, embarrassment, and anger. An analysis of the situations in which whakamā occurs reveals a variety of causes:

(1) Shyness and shame, not only for wrong doing but also for being suspected of it.
(2) Embarrassment over falling short in some respect.
(3) Feelings of injustice, powerlessness and frustration.
(4) Anger with oneself for being in a particular situation.

It is easy to see that a Māori dental patient may feel whakamā:

**Shyness** with being in a clinical situation, a seemingly cold, unfamiliar and intimidating environment of a dental clinic.

**Embarrassment** through dental neglect which has resulted in gross caries and/or periodontal disease.

**Shame** through having to submit a neglected dentition to the dentist in order to receive dental treatment.

**Anger** through feelings of powerlessness at having to be under the control of someone else, the dentist.

The common denominator in the state of whakamā seems to be a feeling of disadvantage and being looked down upon, whether as a result of your actions or the actions of others. The behaviour involves varying degrees of withdrawal from downcast eyes, monosyllabic answers and minimal responses; to a ‘shuttered look’, a stony silence, or an unresponsive immobility; to running away or hiding. Māori can easily recognise whakamā and can then decide how to handle it according to its likely cause. Usually they leave the victim alone for a while to recover, especially if the whakamā is caused by shame for wrong doing. Social isolation, whether inflicted by self or by others, is a punishment for wrong doing. When those around him/her consider the time is right, they
take steps to bring the person back into social circulation. The one treatment guaranteed not to succeed is the one that some people often try in ignorance or frustration: trying to talk them out of it, whether by jollying or scolding. Many young Māori people have their own way of describing being whakamā. It is simply "stink". "I felt real stink" or "He/she made me feel stink" is how whakamā is often described by young Māori (McDowell and Ziginskas 1994).

Whakamā can have any number of manifestations in a clinical setting as the following three case histories illustrate:

Case History 1

A Māori woman aged 30 presented at the University of Otago Dental School Diagnosis Clinic seeking treatment for toothache. After filling out the enrolment forms she sat in the waiting area which was occupied by at least 15 other people. She chose to sit in a squatting position with her head buried in her knees with her long hair hanging down over her front to the extent that her feet were hidden. On examination she was found to have gross caries and severe periodontal disease.

In this case the patient was physically hiding behind herself. It was recognised at once that she was exhibiting the signs of acute whakamā. The reason for her whakamā was the extreme state of dental neglect. What made it worse was that she was required to show it publicly to a total stranger. The clinician in attendance was able to enter into a dialogue with her in an empathetic manner and respond to her immediate dental needs. However, after attending to her immediate dental need she did not return for follow-up definitive dental care.
Case History 2

Mr K was a 35 year old Māori male who sought dental care at Te Whare Kaitiaki dental clinic at the University of Otago Dental School. He was extremely apprehensive and openly voiced his deeply held fears of dental treatment. His treatment plan required the restoration on a number of grossly carious teeth using local anaesthesia and nitrous oxide sedation. As each procedure began he was abusive and demeaning to the clinical staff using indecent language and continually shouting that "I can still **** feel that!"

The patient's angry behaviour was regarded as an extreme case of whakamā. Even though every effort was made to ease his fears and the senior clinical supervisor was called upon to assist with his management, it was not possible to successfully treat the patient. He was advised to seek treatment in private practice.

Case history 3

A mother and father brought their 4-year old son who had been complaining of a severe toothache to the dental surgery on a Sunday morning emergency call-out service. The child was agitated and crying. The mother informed the dentist that the child had had a very bad night with little sleep, crying most of the night. The father would not communicate at all, let alone look at the dentist. His eyes were downcast the whole time and he was completely withdrawn. He never spoke a single word, but chose to seat himself in a corner of the surgery where he remained, physically removed from any participation in the consultation process. On examination, the child was found to have a periodontal abscess adjacent to the decayed root fragment of a lower primary tooth. The child had gross caries with his entire dentition having decayed to the gum level. The child was virtually edentulous.

A general anaesthetic was arranged at the hospital for a full clearance.

In this case the father was suffering as much, if not more than his son. He was in a classic state of whakamā. He was acutely ashamed and embarrassed that he had let his
own child's teeth deteriorate to such an appalling condition. Not only that, his child's dentition was on public display to the dental professional.

*Whakamā* is a concept that all health professionals must have an understanding of. In severe cases of *whakamā* an incorrect diagnosis of depression or even schizophrenia could be made.

### 5.2.2.3 Māori cultural identity

A fundamental aspect of *te taha hinengaro* is cultural identity, which is about knowing who you are as a Māori person. It also means knowing and understanding what ‘being Māori’ is. The Hunn Report of 1960, which opted for a policy of assimilation and the gradual Europeanisation of Māori people, was firmly rejected by Māori. The report (Hunn 1960) stated:

> Here and there are Māoris (sic) who resent the pressure brought to bear upon them to conform to what they regard as the Pākehā mode of life. It is not in fact, a Pākehā but a modern way of life, common to advanced people (Japanese for example) - not merely white people - in all parts of the world. Indeed some white people, everywhere, are not able to make the grade. Full realisation of this fact might induce the hesitant or reluctant Māoris (sic) to fall into line more readily.

All Māori people want is their right to be Māori which was guaranteed under Article II of the Treaty of Waitangi (Sharples 2006a). Subsequent to the Hunn Report there was an assertion by Māori to retain, protect, hold on and promote Māoritanga or their own Māori culture. The expression, *kia a mau ki tō Māoritanga* (hold fast to your Māori culture) was a common expression in whaikōrero (speech making) and waiata (song). The term ‘Māori renaissance’ also entered into the dialogue of New Zealand society as Māori aspirations became more overt and public.
There are three aspects to cultural identity that are important: whānau (family), whenua (land), and te reo (language). These three things are the basis on which cultural identity depends. Cultural identity is the very thing upon which mental health and well being depends. Today Māori want to live in New Zealand as Māori. As such, many Māori do not want to feel that when attending a health service they have to leave their “Māoriness” at the door. This is one of the reasons why the number of Māori health service providers grew considerably during the 1990s; they operate under what is referred to as a ‘kaupapa Māori’ approach. The underlying key success of Māori health providers is that their Māori client group identify with them immediately. For example, Māori mental health worker stated (Ministry of Health 1994) that when a Māori person enters a Māori health service for the first time “they know that the process is not foreign to them”, so it is naturally acceptable.

5.2.3 Te Taha Whānau (The Family Dimension)

5.2.3.1 Māori society

Te taha whānau recognises the importance of the function and role of the family in providing sustenance, support and an environment conducive to good health. Whanaungatanga (kinship ties) provides a sense of belonging, identification and collective strength. The sense of belonging and whakapapa (genealogy) is important: a Māori person belongs to a whānau (family), which belongs to a hapū (subtribe), which belongs to an iwi (tribe), which links back to a waka (canoe) (Durie, E. 1987). Whānau was the basic social unit of Māori society. In former times it consisted of a family of up to 30 or more people, made up of three or four generations at any one time. They lived together under the guidance of kaumātua and kuia (elders). There were children, grandchildren and great-great-grandchildren and their spouses. Today the whānau is still the basic social unit of Māori society. It is not just the nuclear family of ‘Mum, Dad and the
2.1 children’, but it is still very much the extended family. Whānau is the extended family system that embraces all the whakapapa (genealogy) and the present day neighbourhood support ties. The whānau is still the main social, living and learning unit in Māori society. Thus the whānau should have all the resources and skills to provide the sustenance, the support and the environment that is needed for good health. Unfortunately, this is not always the case and as a result Māori do have health and social concerns that have been made worse or have come about through the breakdown of whānau infrastructures.

5.2.3.2 Urbanisation of whānau

The major impact upon Māori in the latter half of the 20th Century was the post-war migration from what was an essentially rural environment to an urban environment brought about by economic necessity. The major shift occurred throughout the decades of the 1950s and 1960s so that by 1986, 80 percent of the Māori population lived in an urban setting (Pōmare and de Boer 1988). Urbanisation resulted in dislocation and fragmentation of Māori social structures. Māori also had to contend with racism in education, employment, and housing (Walker 1987). As a result, the immediate post-war period was a struggle for Māori people in coming to terms with urbanisation; for many Māori people, the struggle was one of survival. Many Māori today believe that the root cause of social problems and health problems is the breakdown of whānau. Māori have been at odds with European cultural influences which tend to have a general emphasis on the nuclear family rather than the extended family. Māori also acknowledge a breakdown of the whānau, the extended family structure such that the kinship ties are weakened and eroded (Tukukino and Te Ahuahu 1987). As a response to urbanisation many Māori have come together to form new social groupings (which are not necessarily based on birth or whakapapa) to provide support for each other. These whānau groups are based on a common element such as work, school, church, sport and recreation, cultural performance groups (Metge 1990), army platoons and even gangs. The post-war era has
seen the rise of urban marae which are multi-tribal or pan-tribal. In addition to these new marae, urban Māori authorities have also developed which provide health and social services, including dental services, for their communities.

3.2.3.3 Whānau tautoko (Family support)

Whānau tautoko (family support) in the clinical situation is important for many Māori when attending health care services. It is recognised as a natural part of kaupapa Māori health services. The term ‘the whānau concept’ in the clinic has been widely used as Māori health services have developed. Dr David Tipene-Leach is a Māori GP with a vast experience of working with Māori communities. He stated (Tipene-Leach 1994):

Māori will often show up at the clinic with the whole family, all having something wrong, from the baby who has been ill for one day, to the two aunties complaining of their 3-year old problems... I now find it hard to interview people without their family around. It also offers a wonderful chance for you to be able to confirm the things that the patient is telling you, as often the patient will be understating their own symptoms and you will only get the real truth from other family members.

The same scenario does fit well with dental health services, especially those that are under the umbrella of a Māori provider. The Māori dental service Te Whare Kaitiaki at the University of Otago Dental School has been referred to as “Te Nihoniho Marae” by a group of kaumatua who saw the clinic as “their whānau clinic”. The clinic is often referred to as ‘the “whānau clinic” rather than Te Whare Kaitiaki by Māori. The patients feel free to bring as many whānau tautoko (family support members) as they please. It is not uncommon for one patient to arrive at the clinic with three or more extended family members.
The social impact of poor oral health is important. Poor oral health can be a barrier to employment. This was revealed very clearly in the dental health project at Rātana Pā, a Māori community with a high rate of welfare dependency. Once the dentitions of some unemployed people were restored they were able to gain permanent employment. One person commented that "The spin-off have been amazing. Getting a wage brought into the house is a huge buzz. Fixing up the teeth did that" (Broughton 1995b).

*Te taha whānau* is therefore vital for health and well-being. It acknowledges the importance of the function and the role of the family in providing sustenance, support and an environment conducive to good health. The classic maxim states: *I think, therefore I am*. The Māori says: *I belong, therefore I am*.

5.2.4 *Te taha tinana* (The Physical Dimension)

*Te taha tinana* recognises the physical and bodily aspect of a person. It is that aspect that western medicine has tended to focus upon. For the Māori, it cannot be dealt with separately from the other three cornerstones, the family, the mental and the spiritual dimensions. The concept of *tapu* is very important. The human body is regarded as *tapu* with some parts of the body, such as the head and genitals particularly so. A sick person is *tapu*. A dead person is very *tapu*. Those in association with a deceased person also become surrounded by *tapu* themselves. When people leave the presence of a deceased person the *tapu* is raised from them through a variety of specific rituals (Ngata 1987).

The head is regarded as the most *tapu* part of the body: it is from the head that the emotions are expressed; it is here that the mental ability is centred; it was from here that the breath of life was breathed by Tāne into Hīne-ahu-one to create the first human being. The importance of the *tapu* of the head was revealed in a story about Colonel Awatere, Commanding Officer of 28th Māori Battalion at the end of World War II which
was documented in the biography of the Padre, Reverend Wiremu Wi te Tau Huata (Spence 1994). They were part of the Occupational Forces who were making an inspection of a defeated Germany and its remaining military installations.

Eventually they arrived at Hitler's redoubt, a magnificent place in the mountains. Hundreds of Allied top brass and also soldiers everywhere. Colonel Awatere and his officers entered a huge hall where generals by the dozens were already there curiously inspecting this famous place where Hitler and his highest ranking staff planned their campaigns and battles.

As the top brass of the 28 Battalion walked slowly across this huge ballroom, they all noticed that Colonel Awatere was not with them. They looked back and there was Awatere urinating on the carpet in full view of the other dignitaries. Wi Huata and the other officers rushed back and grabbed Awatere but he pushed them aside and said to them, 'I am not finished yet!' Wi said to Awatere, 'You can't do that here'. 'Watch me', said Awatere. Then he said, 'You know the greatest thing in Māoridom when you capture your enemy is to eat his head. This is our highest form of revenge. Well, as he is not here, the next best thing I can do is piss on his carpet!'

It is reasonable to generalise that many Māori people do not like other people invading their personal head space. Many Māori do not go to a hair dresser or barber for this reason. Instead, a particular family member may be responsible for cutting hair and disposing of the hair clippings in an appropriate manner. In Māori society when food is being served, especially on formal occasions, waiters and waitresses are particular that food is not passed over a diner’s head. Food is an agent to whakanoa (or make things free from tapu), and to transgress in this way is to demean the mana of that person. Some Māori may take offence if another person was to tap or touch them on the head. One of the lengths that some Māori will go to protect their personal head space is to avoid seeking dental care. If they have to attend dental care then the treatment option of choice is often that which requires the least amount of clinical time; an extraction may be the
preferred treatment rather than a restoration. Some Māori find it very uncomfortable having to submit themselves to another person who literally invades their personal head space. Whilst this position of apparent helplessness is common to many people it is thought to be one of the reasons why dentistry has rated very low with some Māori people.

Problems can occur in the interaction between a health professional and a Māori patient if there is a lack of understanding about the concept of *tapu*. As a general rule in Māoridom, the two ends of the alimentary tract are always kept very much apart. Aspects pertaining to the head are kept quite separate from the back-side. For example, to sit upon a pillow can be very offensive; one does not put one’s backside where one would lay one’s head. Likewise to sit upon a kitchen bench, dining table, or food preparation area is also very offensive to Māori. In hospitals, many Māori take exception to a bed pan being placed upon a tray table where they would normally eat (Otago District Health Board 2006a).

There are particular issues surrounding the extraction of teeth. Many Māori after having teeth extracted may wish to take the tooth away with them. There are culturally specific reasons for this. Firstly the Māori patient may wish to have the tooth returned back to Papa-tū-ā-nuku, the Earth Mother from whom they are originally derived. Secondly they may wish to dispose of it themselves in an appropriate manner secure in the knowledge that it is safe and can never be used by another to effect an *utu* (revenge) through a *mākutu* (curse). In my clinical experience I have found that there is something about the ‘forty-ish’ age group. Below the age of ‘about 40-ish’ some 50% of Māori patients wished to take their extracted teeth. Over the age of ‘about 40-ish’ virtually all Māori people wished to do so. Dental practitioners should in fact make a point of asking Māori patients if they wish to take their extracted teeth. Some Māori who may wish to do so become *whakamā* (shy) about asking.
5.2.4.1 Oral health status of early Māori

Elsdon Best who was regarded as “the last of a small number of students who could write of traditional Māori custom and belief from first hand experience and long personal contact with Māoris (sic) of an older generation,” described the dentition of early Māori (Best 1924):

In his teeth the Māori possessed his most remarkable feature – they were large, white, regular, and remained sound into old age. In old skulls one notes teeth worn down to a surprising extent, but still perfectly sound. An expert has stated that the Māori has the finest teeth in any existing race.

The ‘expert’ referred to was Professor Pickerill, the first Dean of the University of Otago Dental School.

J H Scott, Professor of Anatomy at the University of Otago presented a lengthy paper on the osteology of the Māori to the Otago Branch of the New Zealand Institute in November 1893 (Scott 1893). He had made an extensive study of the skulls of early Māori and found that “in no case have I been able to observe the slightest sign of dental caries.” He noted however that there were “the cavities of alveolar abscesses” in just seven of the skulls he had examined. Scott also reported that apart from the second and third molar teeth, all other teeth showed a marked degree of “wearing-down.” He observed what he referred to as a “curious condition” in which the first molar teeth of the maxilla were worn down at an oblique angle with wear on the buccal aspect being most pronounced. Scott also observed that the chewing-surface that resulted was rounded from within outwards. In extreme cases he found that the tooth had become dislocated inwards.
The definitive account of the oral health status of early Māori was published by Houghton (1980). He stated that there are two distinct periods of time with regard to oral pathology in the prehistory of New Zealand, prior to AD 1500 and post-AD 1500. When the pattern of tooth wear in prehistoric New Zealand is looked at over these two time frames, Houghton noted that “an intriguing picture emerges.”

The earlier inhabitants - before about 1500 - show a pattern of wear fairly similar to the inhabitants of the islands of Eastern Polynesia. At the age of twenty years, the enamel on the occlusal surface of the first molar, which has now been subject to some fourteen years of wear, is only just worn through in two or three places to expose the dentine beneath. The front teeth, particularly the incisors, show rather more advanced wear, with larger patches of dentine. Over the next twenty years of life wear continues slowly but inexorably, with the emphasis continuing to be rather more on the front teeth than the back teeth.

After about 1500...there is remarkable change in the pattern of tooth wear. This now occurs rapidly, with the enamel of the occlusal surface of the first molar sometimes being worn away completely to expose the dentine before the second molar has erupted, at about twelve years.... Such early and extreme wear is widespread throughout the country in this later prehistoric period. There seems to be no recent prehistoric - say post AD 1600 - individuals showing the lesser pattern of wear of the earlier prehistoric period.

Houghton attributes the change in tooth wear to diet, as the slow rate of tooth wear in the earlier period is suggestive of a softer diet. Loss of supporting bone tissue is evidence of periodontal disease. He also noted that there was some caries, “but not commonly”. In the latter period, a more fibrous diet which required heavy chewing of root fern would explain the “extreme tooth wear”. This was referred to as a ‘fern-root plane’ in which
constant chewing of hard fibrous fern root caused attrition of the occlusal surfaces of the teeth, especially the first molars on a sharp oblique plane.

With the change in tooth wear there was a change in the associated pathology. Houghton postulated that heavy amounts of secondary dentine formation eventually broke down with the exposure of the pulp. Infection occurred with the development of periapical abscesses and the tooth was rapidly lost. Wear on the incisors was not marked but maximum wear occurred on the first molar. Periodontal disease, calculus formation and dental caries were almost non-existent in the populations of this later period. Houghton found that skulls prior to 1500 had less tooth wear but more periodontal disease. After 1500, teeth were found to be badly worn down, with abscessing and tooth loss. This latter situation was probably due to a diet which included fibrous fern root and gritty shellfish.

Te Rangi Hiroa (Sir Peter Buck) as Director, Division of Maori Hygiene, presented a paper to the New Zealand Dental Association conference in 1925 on the pre-European diet of the Māori (Buck 1925). He concluded that the marked attrition of the teeth of pre-European Māori should readily be accounted for by the "chewing of hard and fibrous foods in the Māori dietary". The manner in which the fern root was eaten was to insert it into the mouth "in a transverse direction from the side...the rhizome is not bitten off in short lengths, but as the chewing goes on the length is shoved into the mouth, and thus supplies the pressure from without that leads to the inward dislocation of the first molars."

Buck's presentation generated considerable discussion at the conference where it was acknowledged that he had "rendered great service" to the dental profession "by making such an authoritative statement on the subject". The question was asked, "Was the Māori's (sic) diet wholly responsible for his immunity" (to dental caries)? The
Conclusion reached at the conference was that the dental health of the pre-European Māori was due to the "survival of the fittest, coupled with his active open-air life, and his practice of thoroughly masticating his food." However, Brooking (1980) points out that Buck had a "Social Darwinist interpretation to the fact that ancient Māoris (sic) were free of dental disease, whereas contemporary Māoris (sic) suffered from caries and periodontal complaints". That there was little if any caries in the pre-European Māori was that there was no sugar in the diet at that time.

5.2.4.2 The coming of the European

In 1768 Captain Cook had set sail from England on his first epic voyage to the Pacific primarily to observe the Transit of Venus. A transit is when one of the inner planets, Mercury or Venus, goes across the face of the Sun. By timing observations of the Transit from different places on Earth, astronomers were able to work out the distance to the Sun, the astronomical unit which gives a working scale of the universe. Captain Cook's first visit to New Zealand was in 1769. He documented in his journal (cited in Salmond 1991) his observations of the health of the Māori people including one reference to the dentition:

Hardly a canoe came off to us that did not bring one or more old people and every town had several whom if we may judge by gray hairs and worn-out teeth were of a very advanced age. Of these few or none were decrepit, indeed the greatest number of them seemed in vivacity and cheerfulness to equal the young. Indeed to be inferior to them in nothing but the want of strength and agility.

Cook's observation that the teeth appeared to be "worn-out" would allude to the attrition of the occlusal surfaces of the teeth and support the latter anthropological studies by

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8 On 8 June 2004, for the first time in 120 years, there was another Transit of Venus.
Houghton. A number of French explorers who came soon after Cook also recorded observations of the dentition of Māori. Pottier L’Horne was Compagnie officer on board *St Jean Baptiste* which arrived in New Zealand in December 1769. They took on board a Māori named Ranginui, whom L’Horne (Salmond 1991) described as having “very short teeth....as we were examining them he indicated that they had been cut down like that and that it was the custom in his country.” Salmond comments that the patterns of wear on Ranginui’s teeth were “more likely to have been characteristic of ‘fernroot planes’...which have been attributed to a very fibrous diet.” Another French journal keeper, Julien Crozet (Salmond 1991) was second-in-command for the *Mascarin* which sailed from France in 1771. He recorded that “these people often lived to a great age, usually keeping all their hair....and their teeth...which were more used up than spoilt.” Salmond notes again that Crozet’s description of the teeth “probably referred to the harsh pattern of dental wear that resulted from chewing shellfish and fernroot fibres.”

Le Dez was First Lieutenant and Second-In-Command of the *Marquis de Castries* which had sailed from France in October 1771. He compiled a detailed account of his visit to New Zealand (Salmond 1991) noting that “the New Zealanders have...an ordinary sized mouth and strong white teeth.” These strong white teeth had a market in England as Wilks and Jones, two dental surgeons from London in the 1830s bribed healthy Māori to extract their healthy teeth (Gluckman 1976). These teeth were sent back to England for the manufacture of dentures. A French surgeon Felix Maynard who visited New Zealand several times between 1837 and 1840 had complained about this activity fearing for “the ultimate effects of edentulous state on the health of Māori.” According to Gluckman, Maynard “wondered how the aristocratic English wearers of these dentures would react if they realised their dentures had participated in cannibal feasts.”
Another account of the demand for healthy Māori teeth was given to me following a Waitangi Tribunal hearing⁹. In an oral submission it was said that Māori land was being purchased by a settler at the rate of “one extraction for one acre of land.” It could have been that the buyers of the land in this case were Wilks and Jones as it was presumed that the extracted teeth were also being sent back to England for the manufacture of dentures. If this was the case, then the Māori involved were not only losing their teeth, but also their land.

With the coming of the European to New Zealand and the establishment of British settlement, new diseases were introduced which had a devastating impact upon the health of Māori. Associate Professor Huanani-Kay Trask (1989) of the Mānoa Centre for Hawai’ian Studies, University of Hawai‘i, described how Captain Cook and his crew spread tuberculosis and syphilis in the Pacific. Measles and smallpox were also an introduced disease that impacted negatively upon the health of Māori. As the new European culture came to dominate, Māori gradually adapted in their own particular way to the rapidly changing social environment that now surrounded them. Bennett and Broughton (1942) two Otago University medical students, wrote in their thesis in 1942:

The Māori of old no longer survives. In his place is a race of people who are still in a state of flux. Old beliefs persist but newer ones are displacing them. Old habits remain but new ones are being adopted.

Two new habits were tobacco and alcohol which were previously unknown in pre-European Māori society (Broughton 1996). Another new consumer item was sugar. As the causal relationship between sugar and tooth decay is now well established, dental caries could also be regarded as an introduced disease. Some interesting references to the introduction of sugar to Māori are documented in an account of Old New Zealand, A

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⁹ Personal communication, Taranaki Elder, New Plymouth, 6 May 1998.
Tale of the Good Old Times...told by an old chief of the Ngāpuhi (sic) tribe, to Edward Maning (1930) who arrived in the Bay of Islands in 1836. He documented that sugar was given as a ‘reward’ for signing the Treaty of Waitangi:

The next thing we heard was that the Governor was travelling all over the country with a large piece of paper, asking all the chiefs to write their names or else make marks on it. We heard, also, that the Ngapuhi Chiefs, who had made marks or written on that paper, had been given tobacco, and flour, and sugar, and many other things for having done so.

These gifts had obviously been well received according to the documented response after a further presentation had been made (Maning 1930):

Shortly after this, a letter came from the Governor, and with it the Governor sent gunpowder, and lead, and blankets, and flour, and sugar, and tobacco; so we saw then clearly that we were doing right.

Sugar also featured on the shopping lists of the day: Maning (1863) noted that his Māori informant had purchased “Beef, mutton, silk, tea, sugar, tobacco, ostrich feathers, leather breeches, and crinoline…” He also observed the decline in the oral health of the New Zealand population, both Māori and European:

When we first became acquainted with the New Zealanders they had no such thing as decayed teeth or toothache. The oldest people retained their teeth to the last, worn down to the very gums. But when they became accustomed to sugar and consumed it in large quantities and drank hot tea, they soon had decayed teeth and toothache equally with their European neighbours. The teeth of colonial children are invariably bad from excess of sweets.
Gluckman (1976) noted that “the dental health of Māori rapidly declined after European contact.” He stated that by 1880 dental decay was so widespread that it “was almost universal in the Māori.” Both deciduous and permanent dentitions were affected resulting in considerable pain and discomfort. Toothache must have become such an affliction for some Māori if the following extraordinary account of suicide documented by Maning (1930) is to be believed:

I have known young men, often on the most trifling affront or vexation, shoot themselves; and I was acquainted with a man who, having been for two days plagued with toothache, cut his throat with a very blunt razor without a handle, as a radical cure, which it certainly was.

Best had described the teeth of Māori as being “large, white, regular and sound” but his observations were based in the main, on his interactions with the Tūhoe people of the Urewera. John Johnson MD who was appointed as New Zealand’s first Colonial Surgeon in 1840 recorded a different picture for Te Arawa people of Rotorua (cited in Gluckman 1976):

As all the waters are slightly acidulous, food cooked in Ngāwhā (natural thermal water springs) corrodes the teeth, it gives them a blackened decayed look, so that the natives of Rotorua are recognised everywhere by that disfigurement.

Gluckman (1976) noted that Colenso had also “observed such discolouration of the teeth of the people of Rotorua and that the front teeth of Māoris (sic) at Ōhinemutu decayed at a very early age compared to those of other Māoris (sic) and believed this was due to food being impregnated with sulphur during cooking, fragments of food apparently being retained between the teeth.” It is reasonable to postulate that the dental decay of the Māori of Rotorua could have occurred as the result of European contact. The area
attracted large numbers of European tourists who had come to visit the thermal area, to ‘take the mineral waters’ and to see the ‘Eighth Wonder of the World’, the Pink and White Terraces. The children of Whakarewarewa became famous as ‘penny divers’ and their income would have enabled them to purchase sugar and sweets. The tourists also rewarded their hosts and guides with money, sweets and foods containing sugar.

5.2.4.3 Māori oral health status 1900 – 1950

There is a paucity of information on Māori oral health for the first fifty years of the twentieth century. This is no surprise as there had been scant regard for the collection of Māori health statistics since the establishment of colonial rule in New Zealand. The registration of births and deaths was introduced in 1848 for Europeans (compulsory in 1855) but this was not required of Māori until 1913, but even then this regulation was not enforced. There was a requirement to notify causes of death for Europeans from 1872 but this was not required for Māori until 1913. King (1977) states that “the full extent of official negligence in Māori health was well concealed.” Nevertheless there were a small number of documented accounts which provide a snapshot of Māori oral health from this period.

Pickerill and Champtalop (1914) published an account in 1914 of a journey he had made into the Urewera to investigate the causes of immunity to dental disease in Māori of that place. He observed that he had seen “more perfect sets of teeth than I had ever seen before”. Pickerill had attempted to isolate and identify the bacteriological flora of the ‘perfect mouths’ of the Māori children. He found that the variety or organisms isolated “were precisely similar to what one might expect to find in swabs from individuals in an ordinary civilised community.” After a second visit, Pickerill wrote:
The mouths, including the tongues, were in all cases beautifully clean, the teeth regular, and the arches wide; yet their hardest food was boiled riwai or kumara, and Māori bread, with occasionally a scrap of pig or mutton. The teeth were white and well-formed; in no cases could the imbrication lines be detected by the naked eye. Caries, when present in the other children, was found to be almost entirely confined to the younger ones, and in them to the deciduous teeth. This may possibly be a sign of the more recent encroachment of civilisation, which the elder children have escaped.

It is not unreasonable to assume that the Māori people of the Urewera had “perfect sets of teeth” because of their distance and isolation from consumer items, with a consequent lack of sugar in the diet. The Tūhoe people of the Urewera were known as Ngā Tamariki O Te Kohu (The Children of the Mist) and many had deliberately chosen to isolate themselves for many years from the encroaching dominant European culture.

At the outbreak of World War I the young men of New Zealand were called upon to enlist as part of the First Expeditionary Force to serve overseas. The Medical Boards that were required upon enlistment found that the oral health status of young New Zealand males was shocking. Carter (1916) reported to the New Zealand Dental Association in 1916 that 35 per cent of the recruits for military service in World War I were rejected or deferred because of dental conditions. Many potential soldiers required full clearances and dentures prior to joining the New Zealand Division training camp in Cairo. Māori were initially not required to enlist even after conscription was introduced, as a British Government regulation decreed that native troops were not to be used in a conflict between European races. Eventually this regulation was relaxed as Indian troops had been enlisted to fight in France and North Africans were enlisted in the French Army. A Native Contingent, Te Hokowhitu-a-Tū, was formed by Apirana Ngata, which went initially to Cairo before going to Gallipoli and then to the Western Front (Boyack 1989). Whilst there is no information regarding the oral health status of the Māori soldiers, it
would be fair to postulate that their oral health was no better or worse than the other recruits. As a result of the alarming state of the oral health of the enlisting soldiers at the outset of the Great War, the New Zealand Government established the School Dental Service in 1921 to improve the oral health of the population. Expressions such as the 'Murder House' and 'the buzzer' soon became a firmly entrenched part of New Zealand culture for well over 80 years.

Some insight into Māori oral health was to be found in public health theses by undergraduate medical students at Otago University in the 1920s and 1930s. Two such projects were by Butterfield and Kirk, and Stanley and Weston.

Butterfield and Kirk (1930) made a public health survey of Māori life in the East Coast of the North Island in 1929-30. They found that mortality and morbidity from tuberculosis, respiratory diseases and infectious diseases combined with housing and sanitation were the main areas of concern for Māori health. There was very little attention paid to oral health, but that would not be unexpected in a study undertaken by medical students. However, they did note that “social health services” included a school dental clinic which had been established at Tikitiki. Drugs and medication were supplied by the Department of Health to native schools in the area and included such items as cough mixture, tonic for children, diarrhoea powders, hakihaki ointment, itch ointment, tonsillitis gargle and scabies paint. Oil of cloves was also included as “toothache drops”. Butterfield and Kirk included statistics on the oral health status of school children on the East Coast which were acknowledged to Dr Turbott of the Department of Health. (TABLE 5.1)
Table 5.1

Incidence of various conditions in school children, expressed as numbers of cases per 1000. Source: Department of Health, New Zealand, 1929.

<table>
<thead>
<tr>
<th></th>
<th>Māori</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perfect teeth, primary</td>
<td>73.78</td>
<td>31.23</td>
</tr>
<tr>
<td>Perfect teeth, secondary</td>
<td>172.87</td>
<td>19.75</td>
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It is interesting to note that Māori children had double the rate of “perfect teeth” for primary teeth than non-Māori or “White” children and that Māori children had eight times the rate of “perfect teeth” for their secondary teeth as “White” children.

Stanley and Weston (1935) in a study of Māori infant mortality and anaemia in Wellington and Taranaki noted that one particular mother had severe periodontal disease for which she did not wish to seek any treatment. They commented that “this complaint is very common among the Māoris (sic) and is probably the source of many of their illnesses.”

Just over 30 years after Pickerill had been to the Urewera, Saunders and Taylor (1938) also went there in 1936 to conduct a survey of the dental health status and diet of the children who lived in the village of Maungapōhatu. They found that the older children with full secondary dentition had little (if any) caries whilst the younger children with primary dentition had “a remarkably high percentage of carious teeth,” with 44.9 per cent of these teeth being carious. Social isolation by the people had dissipated to a significant extent as both flour and sugar were regular items obtained in bulk and brought back to the Maungapōhatu by pack horse. Saunders et al. commented that “not only are Pākehā foods easier to obtain, but they are also easier to prepare and eat.”
Price (1938), from Cleveland Ohio reported on *Field studies among primitive races in Australia and New Zealand* which he carried out in 1936. In his paper he constantly referred to the Māori people of New Zealand as being of “primitive racial stock” and stated that “in few, if any, countries around the world have the local dental professions so fortunate an opportunity to study these conditions as is offered in Australia and New Zealand.” He found that there was a wide range in the level of immunity to dental caries in the Māori children he had examined. He concluded that the severity of dental caries was in direct proportion to the degree of modernisation, “when modernisation is estimated on the basis of the extent to which native foods have been displaced by the imported foods used by modern civilisation, chiefly white flour, sugar, sweetened goods, canned goods, processed foods including polished rice.” However Price’s interpretations and conclusions were based on raw data as he did not use age standardised statistical analysis or random sampling.

Gruebbel (1950) reported that although the School Dental Service had been in operation since 1921, “the dental health status of young adults who were examined for military service during World War II was not materially improved over that of the recruits in World War I.” An estimate had been made that 50 per cent of recruits in World War I needed or were wearing a full or partial denture whereas 58 per cent of recruits in World War II were wearing some type of denture. Although there had been a reduction of 33 per cent in the need for restorations in the World War II recruits, the “benefit derived from the School Dental Service in terms of extracted teeth or teeth needing extraction was lost by the time the young adults reached the age when they were subject to military service.” Such a large number of Māori enlisted for service in World War II that their own military unit was established, the 28th Māori Battalion. As in World War I, there is no reason to suspect that the oral health of Māori soldiers was any better or any worse than the rest of the Second Expeditionary Force.
Beaglehole (1946) undertook a study of the social life and living conditions of a Māori community in the 1940s. The report was published in 1946 with the actual geographical location given the fictitious name of 'Kowhai'. According to the local school dental nurse, the teeth of the Māori children were found to be “either very good or very bad with little of the half-good, half-bad conditions found in many Pākehā mouths”, and that the permanent teeth were “invariably better” than the deciduous teeth. It was also observed that the dentition of children from “poorer Māori homes” were better than those children from “better Māori homes”. The school dental nurse had suggested that the children from the “better Māori homes” had sweets whereas those from the “poorer Māori homes” did not, although there was no evidence for this.

From the little documented evidence of the oral health of Māori for the first fifty years of the twentieth century a general picture can be gleaned. Those Māori who remained isolated from the European culture and lifestyle appeared to retain a dentition with little if any caries. With time, this isolation broke down and many Māori had greater access to sugar and flour resulting in an increase in tooth decay. Periodontal disease was widespread in adults.

5.2.4.4 Māori oral health status 1950 - 2000
There were greater efforts to collect data and information on the oral health status of Māori in the second half of the twentieth century compared to the first half. There are major deficiencies, however, especially with regard to adult Māori, including young adults.

Hewat et al. (1952) looked at the prevalence of caries in the deciduous teeth of New Zealand children at the mid-century point. Previous investigations (Hewat 1949) had suggested that the permanent teeth of Māori children were “less prone to dental caries than those of European children.” They found that the younger Māori children in the 4
to 6-year age group had more caries than European children, whereas older Māori children at age 8-years were ‘superior’ to European children. Their study was limited in that the number of Māori children was “unfortunately not very large.” Hewat (1954) followed these publications with another paper in the New Zealand Dental Journal in 1954 on *The dentition of the New Zealand Māori today*. This paper depicts a romanticised portrayal of “a race of intrepid sea-wanders,” who had set out on “the fleet” to establish “that mystic union between a land and its people which, fertilized by the dead leaves of centuries, bursts with unexpected beauty into the rich flowering of a national culture.” This paper was published 50 years ago, and it is appropriate to place it within the historical context of the time in which the vast majority of publications concerning Māori people and Māori culture were written by non-Māori people. Hewat does point out that “there is most caries of permanent teeth amongst urban residents and least caries amongst backblock residents; but the differences are less marked in the deciduous teeth.” The most likely conclusion is that the rurally isolated Māori communities had less access to sugar and sugar containing food than those living in the provincial towns and cities. This notion is supported by the fact that up until the immediate post-war period most aerated soft drinks were home delivered by local soft drink manufacturing companies in large stone ware jars of approximately some 5-litre capacity. As there was a cork bung and tap fitted at the base of these jars the shelf life of the soft drink was short. Families living in an urban setting had easy access to this form of soft drink, while rural communities did not. Soft drinks were also available in bottles but were relatively expensive and generally only had on special occasions such as birthdays, weddings and at Christmas time. I have fond memories of the Thompson’s aerated *Cola* soft drink being delivered to the home in large stoneware jars.

In the early 1960s Lugwig *et al.* (1964) investigated the dental health status of a rural Māori population. This was the Tikitiki/Waiapu district at the mouth of the Waiapu River some 90 miles north of Gisborne. A total of 411 subjects were examined which
was 90 per cent of that population with an age range from two years to 75 years and older. They found that the prevalence of caries was high in the deciduous teeth of the Māori children but relatively low in the permanent teeth. They were able to make a comparison with European children living in rural districts throughout the North Island and found that “at almost all ages Māori children have fewer carious permanent teeth.” With the older age groups, there was a change in the oral health status. Young adults in the 15 -19-year age group had a predominance of filled teeth whilst older adults had a predominance of missing teeth. This increased rapidly in the 35 - 44-year-old group who had on average, 25 extracted teeth. Most Māori adults were either edentulous or “nearly so” as a result mainly of periodontal disease.

Two major longitudinal studies are being conducted in New Zealand. The Dunedin Multidisciplinary Health and Development Study (DMHDS) is a long-running cohort study of approximately 1,000 babies born in Dunedin in 1972 (DMHDS 2004). The study members have been assessed at birth, at age three, then every two years up to age 15, and again at age 18 and 21, and at 26 years in 1998-99. A current assessment is being undertaken at age 32. Assessments have included a broad range of studies in psychological, behavioural medicine and biomedical research including oral health assessments. The Christchurch Health and Development Study (CHDS) is a longitudinal study of a birth cohort of 1265 children born in Christchurch in 1977 (CHDS 2004). These children have been studied at birth, four months, one year, annual intervals to age 16, and again at age 18, 21 and 26. Later research has focused upon mental health and personal adjustment of cohort members as young adults. A limitation of both these studies is the low number of Māori participants identified at birth. At that time, Māori ethnicity was determined using a biological definition but this has now changed to a definition based on self identification. Whilst the Christchurch Study did not undertake any physical examinations of the study members, the Dunedin Study has undertaken extensive oral assessments over the study period. However, none of the data on oral
health in the Dunedin Study has been analysed by ethnicity to date. This is currently being addressed\(^{10}\).

The oral health status of Māori from the immediate past is presented within the framework of the Māori life-cycle. The five stages are:

- **mokopuna**: 0 – 4-years, preschool children;
- **tamariki**: 5 – 12-years, primary school children;
- **rangatahi**: 13 – 24-years, teenagers and young adults;
- **pakeke**: adults, and
- **kaumātua**: the elderly.

Whilst this categorisation is arbitrary, it does provide a convenient framework for describing Māori oral health status. It can be regarded as an example of the life course approach (Thomson *et al.* 2003) which "identifies how early occurring events can be related to later outcomes, the multiple routes through which this can occur, and the linkages between biological and psychosocial factors." For Māori, this is an example of *Te Whare Tapa Whā*, the model of health and well being, in action. Overall, Māori do not enjoy the same oral health status as non-Māori across all age groups. For *mokopuna* and *tamariki* ample statistics are available from the School Dental Service. There remains a paucity of valid and reliable data on oral health for *rangatahi*, *pakeke* and *kaumātua*. To gauge an overview of the oral health of Māori young people and adults there is a heavy reliance on anecdotal evidence at this point in time. All District Health Boards and many *iwi* authorities have developed Māori Health Plans for their respective areas, most of which are readily accessible. Whilst these plans contain some reference to oral health status and outlines of strategies to improve oral health, any reference to adult oral health status is anecdotal.

\(^{10}\) Personal communication, Associate Professor W M Thomson.
5.2.4.5 Mokopuna (0 – 4-years) and tamariki (5 – 12-years)

Thomson’s evaluation of ethnicity and child dental health status in the Manawatū-Wanganui Area Health Board (Thomson 1993) revealed that for 5-year-old children:

(a) Non-Māori children were three times more likely than Māori children to be caries free upon completion of their first dental treatment after leaving school.

(b) Māori children were three times more likely than non-Māori children to have high caries experience of dental caries, (five or more missing or filled teeth).

(c) Māori children were three times more likely to have experienced general anaesthesia for dental treatment.

(d) Māori children were over three times more likely not to have been enrolled in the School Dental Service prior to starting school.

Results from the same study showed that for Form II children:

(a) Non-Māori children were twice as likely to be caries-free at the end of their time in the School Dental Service than Māori children.

(b) Māori children were more than twice as likely to have had high dental caries experience than non-Māori children.

This was a landmark paper in that it provided explicit detail on the disparities in oral health status between Māori and non-Māori children. This in turn had considerable impact in providing a driving force for change to improve Māori oral health. Research publications from the immediate post-war era of the 1950s and 1960s did provide some information but these did not lead to a health gain outcome such as improving access to dental services for Māori and Māori oral health promotion.
Koopu\textsuperscript{11}, then a dental house surgeon at Capital and Coast Health in Wellington reported that in 1997, 66 per cent of children referred to the Dental Unit for dental treatment under general anaesthesia were Māori and Pacific Island children. Betty (1998), then a dental house surgeon at Napier Hospital reported on the “disproportionate number of \textit{tamariki} Māori (Māori children) who were referred to the hospital for dental care. He noted that the percentage of Māori children referred for general anaesthetic was “higher than what would be expected from population statistics.” He also noted that the dental treatment need was “more extensive” compared to non-Māori children of the same age. Likewise, Davidson \textit{et al.} (2002) reported that significantly more children under age six years who received comprehensive dental care under general anaesthesia between 1997 and 1999 were from “Māori, Pacific Island and Chinese ethnic groups than would have been expected from the Otago school population.”

Two regions in New Zealand which have relatively high Māori populations are Northland, and Hastings. Oral health status of Māori children from these regions provide a snapshot of Māori child oral health. The water supply in Whangārei in Northland is not fluoridated, whilst the water supply in Hastings is fluoridated.

\textbf{Northland}

A dental survey of 26 primary schools in Northland in July 1997 showed that only 17% of 5-year-old Māori children were caries-free compared to 49 per cent of Pākehā 5-year-old children (Prime 1998). Results from the same Northland study showed that Māori 12-year-olds had a DMFT of 2.09 whilst Pākehā 12-year-olds had a DMFT of 1.02.

In December 2000, National Radio broadcast an \textit{Insight} documentary entitled \textit{An Epidemic of dental decay in Northland} (Williams 2000). The Manager for the School

\textsuperscript{11} Koopu P. Personal communication, Te Ao Marama hui, Ohinemutu, Rotorua, 1997.
Dental Service in Northland, Ms Mary Berrill, said that children in Northland have the worst decayed, missing and filled teeth (dmf) in the whole of New Zealand. She presented the mean dmf for 5-year-old children for 1999 (Table 5.2)

<table>
<thead>
<tr>
<th>Table 5.2 dmf for 5-year-old children, 1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand</td>
</tr>
<tr>
<td>Northland</td>
</tr>
<tr>
<td>Wellington</td>
</tr>
<tr>
<td>Canterbury</td>
</tr>
</tbody>
</table>

When the dmf for Northland is presented based on ethnicity, the picture is much worse (Table 5.3)

<table>
<thead>
<tr>
<th>Table 5.3 dmf for 5-year-old children in Northland by ethnicity, 1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
</tr>
<tr>
<td>Non-Māori</td>
</tr>
</tbody>
</table>

Hastings

Hastings was the first local authority to introduce fluoridation in 1953. Table 5.4 depicts the oral health status for children from Hastings in 2000 by ethnicity (Godbert 2001).

<table>
<thead>
<tr>
<th>Table 5.4 percent caries free for Hastings by ethnicity, 2000.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE GROUP</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>5 years</td>
</tr>
<tr>
<td>12 years</td>
</tr>
</tbody>
</table>

With the disparities in oral health status between Māori and non-Māori in a
fluoridated area, it is little wonder that the anti-fluoridation campaigned have questioned the efficacy of fluoridation (Colquhoun et al. 2002). However there is a confounding factor with these figures in that the assumption is made that the 5-year old children have lived in Hastings for 5 years and the 12-year old children have lived in Hastings for 12 years and therefore lived in a fluoridated area all their lives. Hastings is an agricultural area and was referred to as ‘the fruit bowl of New Zealand.’ It has a high seasonal labour need with people moving into and out of the area for seasonal work. Māori make up a high proportion of seasonal workers and it is highly probable that many of the 5-year old children and 12-year old children who were part of the dental health statistics did not live in Hastings prior to being included in the statistics. The 1999 national data in Tables 5.5 and 5.6 (Thomson et al. 2003) do show that water fluoridation has “clear benefits for different ethnic groups, and contributes to reducing ethnic inequalities in oral health status.”

Table 5.5 Caries severity among New Zealand 5-year-olds in 1999, by ethnicity and water fluoridation status

<table>
<thead>
<tr>
<th>Mean MFT</th>
<th>MĀORI</th>
<th>PAKEHA/other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoridated area</td>
<td>2.2</td>
<td>1</td>
</tr>
<tr>
<td>Non-fluoridated area</td>
<td>3.8</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Table 5.6 The percentage caries-free among New Zealand 5-year-olds in 1999, by ethnicity and water fluoridation status

<table>
<thead>
<tr>
<th>% caries free</th>
<th>MĀORI</th>
<th>PAKEHA/other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoridated area</td>
<td>43.3</td>
<td>69.9</td>
</tr>
<tr>
<td>Non-fluoridated area</td>
<td>27.4</td>
<td>58.3</td>
</tr>
</tbody>
</table>

Overall, Māori children do not enjoy the same oral health status as non-Māori children, even in a fluoridated area. However, Māori children who live in a fluoridated area have better oral health than those who don’t.
5.2.4.6 Rangatahi (Age 15 - 24 years)

There are no actual data on the oral health status of adolescents as there is no data collection process in place. Under the Dental Benefit Scheme, the Principal Dental Officer for an area was able to calculate the mean number of restorations per patient per dentist which was used as a measure to compare the work outputs of individual dentists. Consequently there is a paucity of data on the oral health status of Māori young people as ethnicity data is not routinely collected for those New Zealanders who have enrolled for dental care under the Dental Benefit Scheme. The picture that has emerged is based largely on anecdotal evidence.

Broughton (1993) documented anecdotal evidence of the poor health status of young Māori people aged 18 to 35 years. He described the occasion at a hui with a Māori performing group in 1990 when he was going down "the line" for hongi (the pressing of noses). He was able to make a somewhat rapid, but close assessment of the oral condition of each person (and quite oblivious to each person). The results were alarming. All 40 members of this young group had an obvious dental problem; either gross caries, gross periodontal disease or multiple edentulous gaps involving the anterior teeth. Various combinations of these three situations were evident. Two group members who were edentulous were not wearing dentures. This small convenience sample group clearly demonstrated the status of Māori dental health which was so prevalent amongst the Māori population at that time.

At the present time, the District Health Boards have produced Māori health plans for their respective areas, with most highlighting priority areas based on the eight Māori health gain priority areas and/or the population health objectives listed in the New Zealand Health Strategy. Oral health has been identified as a priority area. All Māori health plans are able to document the oral health status for children, but not for adolescents let alone adults.
Midland Health had reported in 1996 that approximately 50 per cent of Māori adolescents in their region drop out, or do not utilise the dental benefit scheme compared to 25 per cent of non-Māori adolescents (cited in Te Puni Kōkiri 1997). Waitemata DHB reported that during 1997/1998 an estimated 65 per cent of adolescents in Auckland received dental care (Waitemata DHB 1998). This was a substantial fall from the utilisation rates 10 years previously when it reached over 80 per cent, but an improvement on the 50 per cent rate for 1996. The report stated that “anecdotal evidence suggests that low utilisation is especially a problem among Māori, Pacific Island and low socio-economic teenagers.”

5.2.4.7 Pakeke and kaumātua (Adults and the elderly)

There are no recent reliable data on the oral health status of adult Māori. The New Zealand Survey of Adult Oral Health (Cutress 1976) included statistics that substantiated the poor dental health status of Māori people in comparison with non-Māori. The results of this study showed that the adult Māori had:

(a) Many more carious lesions than the non-Māori;
(b) Early and rapid permanent tooth loss;
(c) Become edentulous much younger than non-Māori;
(d) A higher extraction need at all ages; and
(e) A higher periodontal disease prevalence and severity than non-Māori.

This study also showed that many edentulous Māori people did not have dentures.

In the 1976-1982 update there were limitations on the sample size, so the Māori were lumped together in the "Other" category, which was distinguished as "non-white". Virtually the same depressing results were repeated (Cutress et al. 1983).
The Study of Oral Health Outcomes (Hunter et al. 1988) revealed a difference between Māori and non-Māori dental caries in the 35-44 year age group. The DMFT (Decayed Missing and Filled Teeth) for Māori and Pākehā were very similar (20.6 for the whole group) but the treatment each group had received was very different. For Pākehā, the F (Filled Teeth) score was double the M (Missing Teeth) score, whilst for Māori, this was reversed: the M (Missing Teeth) score was double the F (Filled Teeth) score. In this age group, although the caries experience was very similar, the treatment outcomes were quite different; on average, Pākehā were having their teeth restored, while Māori were having their teeth extracted.

Te Whare Kaitiaki is a Māori dental clinic established at the University of Otago Dental School in 1990. A typical case seen at this clinic was a Māori male, aged mid-to-late twenties, who has sought dental care for toothache. On examination he was found to have gross caries and severe periodontal disease. The patient volunteered the information that the last time he sat in a dental chair was when he was in the third or fourth form at high school. Such scenarios are not uncommon.

The dental health programme at Rātana Pā, a Māori community approximately 20 km south of Wangānui, in 1995 revealed a very serious state of dental health status among the adult population, especially in the 20 to 40-year age group (Broughton 1995a). Most of the adults who accessed treatment in the first year of that short three-week programme had very high treatment needs for caries and periodontal disease. Rampant caries was evident with many patients requiring between 20 and 30 restorations. Many of the young women had open carious lesions on the mesial and distal surfaces of all six upper front teeth. What made these teeth look even more unsightly was that these cavities were outlined by black staining. It was as if the edges of the cavities had been outlined by a black felt pen! The labial surfaces of the anterior teeth had marked pitting and black staining. Many of the badly decayed teeth
were beyond saving and extraction was the only option. Comments (Broughton 1995b) from adults who attended for treatment revealed long periods of dental neglect: “I haven’t been to one of you fullahs since I was in the third form at high school. I’m 29 now”, “I dunno when the last time I had to see the dentist; maybe 15 or something years ago.”

Such comments are not atypical of some Māori adults, especially males who are socio-economically deprived. Some people in this unfortunate situation tend to their own dental treatment needs. One person at Rātana Pā (Broughton 1995) commented. “I’ve been able to yank out my own teeth. Yeah, I have aye. I just work on it a bit and then when it’s ready, bingo!”

Broughton and Koopu (1996) found that 27.8 per cent of the people had regular dental care after leaving school. There is a significant drop out of people who have regular dental care after they leave school. Almost 75 per cent of the adults in this study did not have regular dental care.

Dr Tony Ruakere of Te Ātiawa Medical Centre, New Plymouth, a marae-based GP service reported that poor oral hygiene was a major health problem among the 10,000 clients, second only to respiratory disease (Broughton 2000).

The state of the teeth in the patients who attend our medical centre is appalling. Toothaches, broken teeth, oral infections, gum disease, we have the lot. Dental disease is right up there, and there is very little I can do about it.

The lack of any recent definitive data on the oral health status of New Zealand adults indicates a very real need for another national survey. Whilst it is accepted that nowadays more adults are retaining their natural teeth into old age, the dental health needs of the elderly will present more challenges for the dental profession in the first
instance. The development of appropriate strategies and service provision for the elderly will become an area of increasing concern as the post-war baby boomers reach retirement and beyond. Superannuants with limited income will not be able to access routine dental care. Kaumātua (elderly Māori) will have increasing dental health needs.

An important aspect of *te taha tinana* is the health status of Māori. The definitive account of Māori health has been documented by Pōmare et al. (1995). An important consideration in the oral health of Māori is the medically compromised Māori patient. Māori have high rates of rheumatic fever, coronary heart disease, diabetes and asthma which have important clinical implications for dental treatment. Māori have high a need for cardiac surgery intervention but have a low access to this treatment. Pōmare et al. (1988) noted that “there was excessive mortality from coronary heart disease in Māori females, yet coronary heart disease did not feature in the five main causes for hospitalisation for Māori females. Coronary artery disease surgery is an established form of treatment for this condition and may well prolong life. However, the number of Māori people, particularly females, receiving this treatment were few.” In order to have cardiac surgery a patient must be dentally healthy. For some people, a full clearance is required prior to any cardiac surgery. For Māori people with coronary heart disease poor oral health may be a barrier to accessing cardiac surgery. This could possibly account to some extent for the lower numbers of Māori having cardiac surgery.

5.3 *Te Kōrero* (Discussion)

The model of Māori health and well being, *Te Whare Tapa Whā*, provides a most appropriate framework to review the whole area of Māori oral health. This model can be applied to a case (case history 4) described by Broughton (1993) in which a Māori adult sought dental care at *Te Whare Kaitiaki*, the Māori dental clinic at the University of Otago Dental School.
Case History 4:

Mr H. a 65-year old Māori male was referred to the University of Otago Dental School by his cardiologist for the extraction of six remaining lower anterior teeth which were periodontally involved. Following a pre-operative consultation with the oral surgeon, it was decided that the extractions would be done under local anaesthetic with oral sedation. In view of his complex medical history, an anaesthetist would also be in attendance to supervise and monitor the sedation. As the patient was very apprehensive his family had requested that they be present in the surgery to awhi (to provide support and a caring embrace) for the patient. On the day of his surgery, the patient’s wife and eldest adult daughter attended and were seated at a suitable distance from the dental chair. Mrs H. stated that it was most important for Mr H. that his whānau were in his field of vision throughout the procedure. When the anaesthetist arrived in the surgery, unfortunately he had not been informed about the social circumstances and that the whānau would be present. His enquiries about the additional people in the surgery left Mrs H. and her daughter feeling embarrassed and ashamed (whakamā). The situation was made worse for the whānau, because the event was public; it occurred in front of two dentists and two dental assistants. The anaesthetist, on having the situation explained, subsequently apologised and the procedure was completed successfully.

In the context of Te Whare Tapa Whā this case illustrates the four dimensions:

Te taha tinana: The state of health of the patient. The patient had a complex medical history including diabetes, hypertension and coronary artery disease and was taking multiple medications for these disease states. His dental history revealed a long history of dental neglect presenting only for dental care for pain relief.

Te taha hinengaro: The patient was very apprehensive and had delayed seeking dental care for four years for the current complaint. The response by the anaesthetist when he arrived in the operating theatre had left the patient and his whānau feeling humiliated and demeaned. Their mana was trampled upon and as a result they were whakakmā. Broughton stated that the critical factor
in this case was that the whānau felt that their mana had been trampled upon, not only the mana of the patient but also that of the family. The whānau members present in the surgery were not recognised as an important part of the patient’s treatment plan. The dentist was able to reassure the patient’s whānau which then remained in the surgery whilst the extractions were completed without any complications.

**Te taha whānau:**

The presence of the whānau at all times during the patient’s interaction with the dental service was vitally important and a critical part of patient management. Not only were the whānau present in the operating theatre but they were strategically positioned to be in his line of sight at all times. The involvement of the whānau throughout the dental procedures also ensured that post-operative care at home was maintained with no post-operative complications.

**Te taha wairua:**

It was not unreasonable to assume the patient and his whānau perceived attendance at the dental clinic as entering into a fearful situation. As such protective mechanisms effected through wairuatanga (spirituality) are not uncommon. The patient’s wife indicated that karakia (prayers) seeking spiritual support and comfort were conducted at home prior to departing for the dental appointments.
5.4 *Te Whakamutunga* (The conclusion)

*Te Whare Tapa Whā*, the universally recognised and accepted model of Māori health and well being, provides a framework to describe Māori oral health that is culturally appropriate and meaningful. *Te taha wairua* (the spiritual dimension) includes the cosmological belief system which was how the Māori of old explained their world as they saw and lived it. Within this dimension, sickness and bodily complaints including toothache, traditional healing and even death were explained and understood. Concepts such as *tapu*, *tūpuna* and *tohunga* are just as relevant in the modern world and can be comfortably applied to the practice of dentistry today. *Te taha hinengaro* (the mental dimension) embraces the important concepts of *mana* and *whakamā*, two important concepts of which all health professionals must have some understanding. Cultural identity is also an important aspect of the mental dimension. *Te taha whānau* is concerned with the social structures of Māori, the social dynamics within Māori society and the interfaces with non-Māori social structures. The ‘whānau concept’ within health service provision is an accepted part of Māori health services. *Te taha tinana* (the physical dimension) is concerned with the bodily aspect of a person. The *tapu* of the body provides a framework for working with Māori in clinical situations. The health status of Māori including oral health status another important aspect of this dimension. Diet and nutrition, communication and speech and physical facial appearance are important factors influencing the health of the teeth, mouth and the whole body. From the Māori holistic point of view, poor dental health has a marked effect upon over all health and well being. The aim of *He Korowai Orangi* The Māori Health Strategy (King and Turia 2002) is *whānau ora* (the health of the family). This was the thrust of a Māori oral health project by Pacific Health which declared *Orangā niho, orangā tinana, orangā whānau* (Oral health, physical health, a healthy family).

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Chapter 6

Whakapapa

(Lineage)

6.1 Te Kōrero Tuatahi (Introduction)

Whakapapa is genealogy. It describes the descent lines of an individual through both their immediate and extended whānau (family) and links them with their hapū (sub-tribe) and iwi (tribe). Whakapapa is more than a family tree as it links one hapū with another and one iwi with another. Today when we think of whakapapa, we think of all that has gone on before. This determines not only who you/we are, but where you/we have come from in the context of family lineage and lines of descent. The very essence of ‘being Māori’ is whakapapa, as whakapapa denotes both family and tribal identity which gives rise to a strong sense of belonging. Tribal identity denotes a person’s tūrangawaewae (their place to stand or ancestral home base) which affords certain rights and privileges to that individual in a particular rohe (tribal territory) and marae (traditional central meeting place). Mead (2003) states that “whakapapa provides our identity within a tribal structure and in later life gives an individual the right to say, ‘I am Māori.’”

It is considered very important that at the hapū and iwi level, knowledge of an individual person’s whakapapa is known by the wider membership of the hapū and iwi. Such comments as: “He/she is one of us”; “He/she belongs to that family”; “He/she belongs to that marae”; “He/she comes from So-And-So place”; are often heard. A gross insult to a Māori is to ask the question, “Ko wai koe?” (Who are are you?) The implication of this disparaging question is that you are a nobody because you do not belong anywhere, or you are of no consequence because your whakapapa
is not known. Māori often say, “He/she is my relation,” which is a confirmation of that person’s membership within a whānau, hapū and iwi collective. When Tony Brown (whose whakapapa is Ngāi Tahu) became an All Black he suddenly found he had many relations that he never knew he had; many Ngāi Tahu people were claiming him as their own which was their right to do.

The following case history illustrates the importance of whakapapa in a particular clinical situation.

**Case history**

At a 1 Mobile Dental Unit, RNZDC civilian exercise along the far reaches of the Wanganui River in January 1992 a whānau brought their 80-year-old grandmother for dental treatment. The family had requested that her six remaining lower front teeth which were very “wobbly” be extracted. However, before she would allow the Māori dentist to undertake any clinical work she intimated after the greeting and introduction that time be spent discussing their respective whakapapa. It was important for her that the dentist’s whakapapa, his hapū, and iwi were revealed so that she could then link that with her own whakapapa, hapū, and iwi. Once those associations had been established and the whakapapa relationship between patient and dentist was determined, she was quite happy for the dentist to proceed with the extractions.

Encompassed within the notions of whakapapa are tribal histories and mātauranga Māori (Māori knowledge) that has been passed down through the generations. Te M. Tau (2004) states that:

> Everything has a whakapapa. The world is ordered by whakapapa. In the South Island, in New Zealand we identify things genealogically, which means trees, mountains, rocks and rivers. We have genealogies of them. In all these things the genealogies of the rocks, rivers, mountains, trees and people are connected because they all have a whakapapa.
The important aspect of Te M. Tau’s kōrero (discussion) is the concept of “connections”. Whakapapa is concerned very much with how people are connected to each other and how things are connected to each other. Not only does a person have a whakapapa, but an organisation will have a whakapapa which describes the connections of particular people to the organisation and the history of that organisation. A marae has a whakapapa which is a history of its development and the hapū and iwi which grew and evolved from its originators. Likewise a taonga (treasured artefact) such as a mere pounamu (greenstone adze) will have a whakapapa based on its origin and its owners. Barlow (1991) states that “Whakapapa is the genealogical descent of all living things from the gods to the present time....Everything has a whakapapa...” Barlow also describes the meaning of whakapapa as “to lay one thing upon another.” In this context, generations of a family tree can be seen as being laid one upon the other. In the same way the development of an institution, organisation or collective entity can be regarded as having a whakapapa as the various stages of its specific development are laid one upon the other culminating in its present state. Oranga niho has a whakapapa.

6.2 Te whakapapa o oranga niho (The lineage of oral health)

The expression ‘oranga niho’ translates as dental health. Because it is in ‘te reo Māori’ (the Māori language) it is understood that ‘oranga niho’ refers to Māori dental health in particular. Oranga niho is now such a widely used expression that it has universal acceptance. It sits very comfortably along side other expressions within the health sector such as ‘Auahi kore’ (Smoke free); ‘Kia tupato’ (Take care) in injury prevention; ‘Mate huka’ (diabetes); and ‘He mate huangō’ (asthma).

The first time that the expression ‘oranga niho’ was documented as a Māori health entity was for United Nations World Health Day on 6 April 1994. World Health Day
that year was dedicated to oral health. In New Zealand the Public Health Commission (PHC) chose to focus upon oral health in a national awareness campaign and in particular Māori oral health. J Broughton was commissioned to develop an appropriate programme targeting kōhanga reo (Māori pre-schools) with the only constraint being the funding. After consultation with the Māori staff of the PHC, the National Office of Kōhanga Reo and kaumātua (Mr Karaka Roberts) the slogan “Oranga Niho, Oranga Kata” (“Healthy Teeth, Healthy Smile”) was developed. The resources that were designed included a colouring-in template of a stylised Māori figure with a tooth brush including the new slogan, and printed balloons for tamariki (children) (Public Health Commission 1994a). An information pamphlet with the slogan was also developed for parents and whānau (Public Health Commission 1994b). A series of advertisements were also scripted and produced for broadcast on the Māori radio national network. The expression ‘oranga niho’ had entered the contemporary Māori health vocabulary for the first time.

Oranga niho (Māori oral health) gained considerable momentum during the decade of the 1990s and has continued through to the present time. A decade before, the focus was on overall Māori health and well being as Māori leaders throughout the country began to be more proactive in the pursuit of health gains for their people. The Hui Whakaoranga Māori Health Planning Workshop held at Hoani Waititi Marae in March 1984 was to be the spearhead of Māori health development for the ensuing 25 years. An outcome of the hui was the application of Te Whare Tapa Whā model of health and well being as a framework to improve Māori health. The then Department of Health (1984) recognised that “it was no longer appropriate to determine health related programmes without first consulting and involving Māori people.” This was a significant shift and was exemplified by the Department of Health stating that it saw its role as “working in collaboration with Māori people to identify their health needs and to propose initiatives that would be supported at the local community and tribal
level.” The dental profession was represented at the *hui* by Dr Clive Ross, Chairperson of the Council of the New Zealand Dental Association and Dr Stewart Edward, dental practitioner of Rotorua who subsequently made recommendations to the New Zealand Dental Association with regard to Māori dental health (Edward 1984).

A second thrust in the advancement of Māori health and well being came with *Te Ara Ahu Whakamua, the Māori Health Decade Hui* held in March 1994 in Rotorua (Te Puni Kōkiri 1994a). This *hui* consolidated the Māori health gains of the previous decade and focussed the way forward through the identification of specific themes such as *tino rangatiratanga* (self determination). There was no reference, however, to oral health in the proceedings of either *hui* but that was not unexpected as there were other more pressing health issues for Māori at that time, such as heart disease, asthma, diabetes, drug and alcohol issues and immunisation. Two health concerns with important dental implications that were discussed at these two *hui* were rheumatic fever and diet and nutrition, but the proceedings of both *hui* do not make any links of these health indicators with oral health. However, the significance of these important national *hui* was the recognition and acknowledgement of Māori leadership in health. The publication of *Hauora, Māori Standards of Health* (Pōmare *et al.* 1988) had only hardened the resolve of Māori to improve their health status. There was also a lack of any reference to oral health in this publication as well.

The main emphasis for the improvement of Māori health throughout the late 1980s and into the next decade was the development of Māori health services that were delivered by Māori, and the catch phrase, “By Māori, for Māori” became widely articulated. This is not to say that such efforts did not exist prior to this time. In fact considerable efforts had been made over the last 100 years with the work of Sir Māui Pōmare, Te Rangi Hīroa (Sir Peter Buck) and Dr Tūtere W Repa who were the first
Māori doctors (Ngata, P. 2002). They were followed in due course by further generations of Māori doctors (Broughton 1999). Other leaders in Māori health were Sir Apirana Ngata, Princess Te Puea, Dame Whina Cooper and the Māori Women’s Welfare League and Nurse Cameron of the Women’s Health League. The first Māori to graduate in dentistry was Walker Morete in 1920 (University of Otago 2004). The workplace of the emerging qualified Māori health professionals during the 20th century was within a mainstream publicly funded health system or within private practice. Māori health services as we know them today did not come into their own until the mid to late 1980s.

During the 1980s, when a committed Māori leadership was beginning to make significant inroads within the health sector, very little (if anything) was happening with regard to Māori oral health. As early as 1979 the NZ Survey of Adult Oral Health had reported on the poor oral health status of Māori (Cutress et al. 1979) but nothing subsequently had been done to address the issue. The NZ Monitoring of Adult Oral Health Survey 1976-198 (Cutress et al. 1983) had so few Māori participants that they were included in the “other” sample. The Study of Oral Health Outcomes (Hunter et al. 1988) revealed an outcome that Māori adults were only too aware of; they were having their teeth extracted. Despite these surveys, there were still no concerted efforts to address the issue of Māori oral health.

Throughout the 1970s and 1980s, the Royal New Zealand Dental Corps (RNZDC) had undertaken a small number of civilian exercises with isolated Māori rural communities as part of larger Defence Force exercises (Broughton 1993b). These however tended to be haphazard, short term and provided basic dental services that were more inclined towards casualty and/or emergency dental services. Whilst the army was able to exercise its dental personnel and specific Māori communities received some dental treatment, there was no long term benefit or impact. All that
was to change by the late 1990s. Not only was Māori oral health recognised as an area of major concern, it was also recognised as a key Māori health gain priority area. The RNZDC civilian exercises with Māori communities did play a pivotal role in the development of Māori oral health services by highlighting the need for such services.

The driving force for intervention strategies was the increasing public vocalisation of the poor oral health status of Māori. The dental health sector had become more assertive in raising their concerns in the news media. Māori communities had also identified poor oral health as a major health issue and began seeking ways of addressing it. The thrust of Māori oral health development from 1990 onwards was three fold: firstly, the emergence of Māori oral health strategies; secondly, Māori development of oral health services; and thirdly, Māori oral health promotion. These three aspects are in essence the key strands of the whakapapa of oranga niho which evolved and developed concurrently. An analogy is to liken these three aspects to a woven flax cord made up of the three distinct strands of Māori oral health strategies, Māori oral health services, and Māori oral health promotion. The weaving of this cord will be described in a chronological time sequence.

In 1990, Te Whare Kaitiaki, was established at the University of Otago Dental School (Broughton 1993b). It operated within the then Department of Hospital Dentistry for one morning a week during term time. The clinic did not receive any funding from the Department of Health but was established as another service provided by the Dental School. It also had a teaching function, with two final-year dental students being assigned to the clinic each week on a roster system. The patient group were part of the local Dunedin Māori community who chose to access this service. This clinic will be described in full in Chapter 10.
At about the same time, a young dental practitioner in Hamilton (Dr Russell Emerson) was providing mobile dental services to some Māori communities (NZ Herald 1994). He had worked as a dental officer for the Health Department and in private practice in Hamilton and “decided there was a need for such a service.” He began with a caravan and later developed a dental surgery including x-ray equipment to fit into the back of a van which travelled throughout the Waikato. By 1994 he had secured a contract with the Northern Regional Health Authority for $190,000 to include working with Te Whānau O Waipareira Trust, (a large Māori urban authority in West Auckland) providing dental care for children in kōhanga reo. The need for Māori oral health services in the Waikato and South Auckland was identified and funded. North Health was very supportive of Dr Emerson’s mobile dental service and commented:

North Health views the mobile surgery as a first solution for people who are missing out on dental treatment due to financial or cultural considerations.

In September 1991 a group of Japanese researchers carried out a survey of Māori oral health within the Rotorua and Maketū areas of the North Island (Inoue 1993). When they arrived in New Zealand they found that their pre-conceived perceptions of Māori were quite different as they “recognised soon that they looked something quite different from our image. They are evidently regular citizens in civilized society, not terrible ones.” This project gained the support and cooperation of the Tipu Ora Trust, a Māori health provider in Rotorua. Without this support it would have been difficult for the project to proceed as it was the Māori health service that was able to provide the necessary Māori community networks. The project report concluded that:

Living people in Rotorua area have been losing their oral health condition. 80.1 per cent of living people had dental caries and 56.1 per cent had gingivitis.
They also reported that there was a lower treatment need in the younger generation which they put down to:

This glorious fruit of overcoming dental caries is accomplished by the School Dental Service system in New Zealand which is supported by excellent dental nurses and enrols the children of both Māori and Pākehā (New Zealand White).

Whilst this project was not initiated by Māori, it was the Māori health provider who gave considerable support and mana to the project which enabled it to proceed. The beneficial outcome for Māori was that it raised the profile of oral health amongst the Māori community in Rotorua. This had important implications for the later development of a marae based dental clinic in Rotorua under the auspices of the Tipu Ora Trust. This will be discussed in Chapter 8.

Throughout the early 1990s the poor status of Māori oral health was being reported in the news media. In Palmerston North, the Evening Standard (14 December 1992) ran a head line, “TOOTH DECAY RISING IN YOUNG MĀORI”:

Tooth decay has increased suddenly among young children in predominantly Māori areas, the Health Department says. Seventy-eight percent of five-year-olds at Cannons Creek Primary School had tooth decay last year, compared with 56 percent in 1989.

In Levin, The Chronicle (3 March 1993) reported on “POOR DENTAL HEALTH RESULTS FOR CHILDREN”, highlighting that Levin and rural Horowhenua (which have relatively high Māori populations) were “the worst affected areas” in the Manawatū-Wanganui area health board regions.
In Christchurch, *The Press* (1992) reported under the head line, "TOOTH DECAY DOWN":

Tooth decay has fallen dramatically in all age groups in the last 15 years, according to the Department of Health. The department said New Zealand had gone from having one of the highest rates of tooth decay in the developed world to a very low level.

The report was based on the results of the 1988 World Health Organisation Oral Health Outcomes study. The news item also reported:

As in previous surveys, Māoris and those on low incomes had greater problems with their teeth.


Decaying teeth in Māori and Pacific Island five-year-olds could be a result of the increasing unemployment of their parents, a survey has found. A five-year study of the dental health of five-year-olds in the Manawatu-Wanganui region showed the rate of decay in the teeth of Māori and Pacific Island children matched the rise in unemployment.

Not only were Māori oral health issues being highlighted in the media, Māori were also discussing it with increasing concern. *Oranga niho* became a frequent item for discussion at Māori health *hui*. For example at the first Māori health research *hui* hosted by the late Professor Eru Pōmare at the Wellington School of Medicine in 1993 a *kuia*¹ (a respected elderly Māori woman) from the Bay of Plenty asked about

¹ Personal communication, 17 May 1993
oral health services and what if any research had been done with regard to Māori oral health. Asked why she brought up the subject of oral health she replied:

*My son was made redundant from his job in the engineering design business and had been unemployed for over a year. A new position came up with a big firm and he was shortlisted for an interview. I was confident he would get the job because he had the qualifications and he had the experience. Well when he came home I said to him, "How did it go Son?" He replied, "As soon as I opened my mouth, they said the job was taken."*

The social impact of poor oral health was highlighted by this *kuia* who said, “No wonder he never got the job with his teeth being so bad. When he hasn’t got a job, how can he afford to get them fixed up?” With poor oral health being identified by Māori as a barrier to employment, the impetus to develop pro-active strategies began to gather increasing momentum.

A survey of Māori women and smoking (Broughton and Lawrence 1993) revealed a perceived association between smoking and oral health with 5.3 per cent of the research participants stating that smoking was a cause of bad breath. One person commented, “Every time I have to kiss someone who smokes, it almost makes me throw up.” Such comments became more and more frequent. Some Māori communities were determined to eliminate negative life style factors such as smoking that impacted upon the health of their people. Tainui in the Waikato declared all their *marae* smoke free (Otago Daily Times 1992). Oral health along with smoking was identified as a major health issue within Māori communities and community leaders working at a local level were taking considerable efforts to address the issues. Ōtaki is a good example. A *whaea* (a respected older Māori woman and grandparent) who
was a community volunteer was doing her best to support and assist young Māori mothers with parenting skills in the Horowhenua. She told the following kōrero (story):

*We have had an increase in young families moving to Otaki to live, mainly from the Wellington area. This all started after the Government increased the rentals for state houses to market rentals. Although there was meant to be an accommodation supplement for people on low incomes, it was still very hard for our young ones. So they moved to Ōtaki where our rents weren’t nearly so dear as in Wellington. Well I noticed that a lot of those young people had terrible teeth. Not only that they were suffering from the aches and pains of toothache. Well we only have one dentist in Ōtaki and they don’t like to go to see him because he is in the same medical centre as the doctor, and they owe the doctor money as they have unpaid bills with him. They have to get passed the doctor’s receptionist to get to the dentist! Well this got to be such a big problem for us that we had to do something about it. What we wanted was a dental service for our people that they could afford. So we wrote to the Minister of Health, Mrs Jenny Shipley, about it and we were lucky that we managed to get an appointment to see her. So off we went to Wellington and told her all about the lack of affordable dental services in our area and could she please help us. Well she told us that we should access the dental services that were at Palmerston North Hospital as it was only 45 minutes drive away. Now that was great except that our young people at home do not have cars and there is no public transport. So our people are still suffering.*

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2 Māori health community worker, Ōtaki. Personal communication, Dunedin, 1999.
The community health group at Ōtaki then sought the possibility of an army dental exercise being held in their area which would have addressed much of the immediate dental health needs. Such military exercises had been held from time to time in different parts of the country as a means of ‘winning the hearts and minds’ of the local community. In the summer of 1992 the New Zealand Defence Force had conducted a major exercise, Exercise Vital Link, in the Central North Island and as a project for the civilian population 1 Mobile Dental Unit, Royal New Zealand Dental Corps provided dental services for the isolated Māori communities along the Wanganui River. Dental surgeries were set up on the marae located at Ātene, Rānana and Pipiriki over a two week period providing a much needed and appreciated service for the local communities (Broughton 1993b). However, such a programme did not eventuate in the Horowhenua region.

Rātana Pā is a Māori community approximately 20km south of Wanganui. It was founded in the 1920s by the prophet Wiremu Tahupōtiki Rātana who established the Rātana Church which has over 37,000 adherents today (Keith 1984). As a result of the successful Defence Force civilian dental project along the Wanganui River in 1992, the Māori health community worker at Rātana Pā sought a similar programme for the people of Rātana Pā. She too had identified oral health as a major issue within her community and entered into negotiations with the Dental Unit of Good Health Wanganui. Eventually funding became available through the Central Regional Health Authority in 1994 which allowed a mobile caravan to be on loan from the School Dental Service and to be staffed by a contracting dentist. Broughton (1995a) discussed the success of this one-off three week programme which resulted in further funding for three months in the second year and for “effective monitoring and maintenance of healthy dentitions” in the third year (Rourangi et al. 1996).
A small Māori driven dental health initiative occurred at Arowhenua in South Canterbury. The Māori health community worker for Primary Health Services in Timaru had identified oral health as an issue of concern. She organised an oral health day at Arowhenua Marae on 18 August 1992 which involved the local school dental therapists and two dental surgeons who conducted free clinical examinations and oral health promotion (Timaru Herald 1992). Sixty-five people took advantage of the occasion and “only about a third of those seen were referred on for further treatment.” This community initiative which was driven by Māori to begin to address oral health occurred as a result of the support and cooperation of the local dental health sector. It was an example of the type of community based health project that was happening in other parts of the country.

In the summer of 1994-95, Pauline Koopu, then a fourth year dental student at the University of Otago Dental School was awarded a Health Research Council of New Zealand Summer Studentship in Māori Health Research. Her research project, Dental Health Services and Māori People (Broughton and Koopu 1996) was to undertake a survey of Māori adults to ascertain their access to and usage of dental health services. The main findings of the survey were that 99.7 per cent of the survey participants had dental care as a child in the School Dental Service; and 82.5 per cent were enrolled in the Dental Benefit Scheme as teenagers, but only 27.8 per cent of people had any regular dental care after leaving school. The report identified the dental health messages that should be conveyed to Māori and recommended that the “dental profession must make dental health messages more effective for Māori people.” The report also recommended that improvement in Māori health gain can be made by the development of “joint partnerships with Māori.” At the completion of the project and the publication of the report a hui (conference) was called to disseminate the research findings. The pānui (announcement) for the hui went out nationally for the “First National Māori Oranga Niho Hui” to be held in Rotorua in February 1996.
At the same time as this national conference for Māori oral health was being planned, Te Puni Kōkiri (the Ministry of Māori Development) in Wellington was also proactive in the development of policy for oranga niho. A hui (conference) in Gisborne on 1 December 1995 was called inviting Māori dentists, school dental therapists and others in the dental health sector “to discuss the current and future health needs of Māori.” The hui was planned “to enable Te Puni Kōkiri to consult with Māori presently working in the area of dental health, and to gain some feedback on what the important issues might be for Māori communities.” ³ The significance of this meeting was that the development of strategies for the improvement of Māori oral health was being initiated. The Social Policy Branch of Te Puni Kōkiri⁴ stated that as a result of the hui, “Te Puni Kōkiri views dental health as being an issue of major concern, and will continue to work closely with the Ministry of Health on ways in which the dental health needs of Māori can be more effectively addressed in the future.” The outcome of the hui was a number of recommendations for further action (Te Puni Kōkiri 1995):

• Māori dental health be given a higher profile;
• improved dental health of rangatahi become a “priority” for government agencies;
• strategies and policies be developed to overcome the dental health needs of Māori;
• the expertise of School Dental Therapists be recognised and that strategies be developed which effectively utilises their skills base;
• more funding be made available;
• Māori specific research be developed and undertaken;
• a Māori Dental Health Association be established;

• more marae based and/or iwi health authority dental health programmes be developed and implemented;

• more portable dental services be established to service rural areas;

• Māori specific dental health education resources be developed for Māori Community Workers, School Dental Therapists and Dentists to promote, educate and raise the awareness of good dental health practices amongst iwi/hapū/whānau/Māori;

• access to specialist services be improved for Māori;

• access to quality care be improved for Māori;

• strategies be developed that encourage rangatahi to take up science subjects while at school;

• iwi and government agencies provide training scholarships for Māori wishing to pursue a career in the dental field; and

• Te Puni Kōkiri support the first National Dental Hui to be held in Rotorua during February 1996.

This hui was a significant milestone in the whakapapa of oranga niho, as a government ministry had recognised that Māori oral health was an issue of major concern and that strategies needed to be put in place for the development and implementation of policy. An analysis of these recommendations reveals that they cover all three areas of Māori oral health development: Māori oral health strategies, Māori oral health services and Māori oral health promotion. The whakapapa of oranga niho from this point on will be discussed in the light of these three areas.

6.3 Māori Oral Health Strategies

Key strategies for Māori oral health gain that were formulated and moved forward by Māori were:
1. The establishment of a national Māori voice for Māori oral health (This was achieved through the establishment of Te Ao Mārama, The New Zealand Māori Dental Association);

2. Māori participation in the dental health sector;

3. The development of the Māori dental health workforce; and


6.3.1 Te Ao Mārama. The New Zealand Māori Dental Association

One of the key oral health strategies that came out of the Gisborne hui was the recommendation for the formation of a new national Māori health organisation with the kaupapa (philosophy) of Māori oral health. This occurred during the First National Hui Oranga Niho held at Ōhinemutu, Rotorua, 9-11 February 1996. This hui had been called and organised by J Broughton as a means of disseminating the results of the Māori oral health research project Dental Health Services and Māori People back to the Māori community (Broughton and Koopu 1996). J Broughton received a grant from the Māori Committee of the Health Research Council of New Zealand for this purpose. The hui was hosted by Mrs Inez Kingi, a retired school dental therapist and her husband Mr Pihopa Kingi, both well known kuia and kaumātua (elders) of Ngāti Whakaue of Ōhinemutu, Rotorua, The hui was held in Te Ao Mārama, the whare (house, but in reality is a large community centre) of the Women’s Health League on the shores of Lake Rotorua. Over 50 Māori dental professionals attended the hui which included five Māori dentists, Māori school dental therapists, Māori health community workers, Māori nurses and other Māori health professionals. The hui “unanimously agreed that a new national Māori organisation should be established under the kaupapa of oranga niho.” (Te Ao Mārama 1996) The discussions about establishing a new national organization centred around the building of a new whare.
The *tūapapa* (foundations) of this *whare* was the *kaupapa* (mission statement) of the new organisation:

*Hei oranga niho mō te iwi Māori.*

This translates as oral health for all Māori. The framework for this new *whare* was identified as the structure of the organisation, the officers and members, and the committee and sub-committees that may be formed. The four walls of the *whare* were identified as “our processes, the way we do things; our *mahi* (work); our commitment; and our collective strength.” The roof of the *whare* was *tikanga* Māori (Māori custom and protocol) which covers and embraces the Māori nature of the organisation. The *tāhuhu* (ridge pole) of the *whare* was identified as *hauora* Māori (Māori health in general) and the *pou tokomanawa* (the carved posts of the *whare*) were identified as the objectives of the organisation. The *hui* identified the objectives which were discussed at great length over the ensuing 12 months, modified and presented back to the organisation at the second national *hui*. The objectives adopted and confirmed at the first annual general meeting were:

1. To uphold Māori oral health as guaranteed under Te Tiriti o Waitangi;
2. To pursue the delivery of oral health services to Māori at the optimum level;
3. To safeguard and promote the oral health of te *iwi* Māori; and
4. To promote the opportunity for te *iwi* Māori to access quality oral health.

The officers of Te Ao Mārama elected at the first *hui* were Mrs Inez Kingi, President; Mr Pihopa Kingi, *kaumatua*; Mr J Broughton, secretary; Mrs C Rimene, treasurer; and a steering committee of 6 people. The officers and steering committee were able to meet in Wellington on 25 May 1996 to discuss a new constitution and to plan the
future direction and activities. This hui was made possible through the support of Te Puni Kōkiri, the Ministry of Māori Development who recognised that such support for a new national Māori organisation was critical throughout its developmental stages. Te Puni Kōkiri continued this support in the following year which allowed the officers and committee to meet on three occasions to develop a strategic plan. Te Ao Mārama produced a regular Newsletter for its members and a Journal to enable the dissemination of information, maintain networks and promote a sense of ownership amongst the growing membership. The membership of the Te Ao Mārama was “open to Māori school dental therapists, Māori dental surgeons, Māori dental specialists, Māori dental hygienists, Māori dental technicians, Māori dental assistants, Māori dental administrators, Māori students of dental science, Māori health community workers, Māori health researchers, other Māori health professionals and Māori people committed to hauora niho” (Te Ao Mārama 1997a). This differed from the New Zealand Dental Association which is the professional body for dentists only. The minutes of the inaugural meeting of Te Ao Mārama The New Zealand Māori Dental Association state that, “if you whakapapa to this new whare, Te Ao Mārama, then you are part of te rōpū (the group)”. (Te Ao Marama, 1996a) This statement confirms the notion that an organisation has a whakapapa.

The important significance of this new Māori health organisation was threefold. Firstly it was recognised as the national voice for Māori oral health. Te Ao Mārama was a collective of expertise in dentistry and oral health that was steeped in te ao Māori (the Māori world) of ‘all things Māori.’ Secondly, Te Ao Mārama was recognised as the body to consult with by the health sector on matters pertaining to Māori oral health. The Dental Council of New Zealand, The New Zealand Dental Association, The New Zealand Dental Therapists’ Association, The Ministry of Health, The Health Funding Authority (and later the DHBs), and Te Puni Kōkiri all recognised the mana (standing and authority) of Te Ao Mārama and the contribution
that it would make to the health sector as a whole (Delamere 1998, Turia 2000).

Thirdly, Te Ao Mārama was regarded by its members as a ‘flax roots’ organisation
with a strong community base. Although Te Ao Mārama is first and foremost an
organisation for Māori health professionals, it has extensive Māori community
networks, community support and active community involvement.

Te Ao Mārama and its organisation gained increasing recognition from government
ministers. At the opening address of the New Zealand Dental Association Conference
in Dunedin on 4 October 2000 the Minister of Health the Hon Annette King stated,
“I am particularly pleased to see Dr John Broughton will speak on current issues in
Māori dental health…” (King 2000d). The Associate Minister of Health, the Hon
Tuariki Delamere speaking at the third Hui-A-Tau (annual conference) of Te Ao
Mārama said, “It is time the health sector and Māori communities put dental health as
a priority and I applaud the work that you in Te Ao Mārama are doing to achieve this”
(Delamere 1998).

This approbation by Delamere was put into perspective by Durie (1998) who stated
with reference to both Te Ao Mārama and Te ORA the Māori Medical Practitioners’
Association that:

While it is unlikely that either Association will make an immediate difference,
at least in terms of the number of Māori doctors, dentists, and allied health
professionals, an important point is that there will now be a forum whereby
Māori health experts might more effectively address Māori health issues,
utilising their expertise, and at the same time increasing the opportunities to
interact with Māori communities as well as professional networks.
6.3.2 Māori participation in the dental health sector

This was a key strategy for Māori health which was identified by the Māori Health Commission who stated (Māori Health Commission 1998b):

An important strategy for the improvement of Māori health is the active participation of Māori throughout the health sector. The Commission is working towards ensuring that Māori participation in the health sector is across the board. The goal is to create effective Māori participation in the development and control of Māori health resources and services in the mainstream.

The Chairman of the Māori Health Commission was Mr Wayne McLean who was also the Chief Executive Officer of Raukura Hauora O Tainui, a large Māori provider in the Waikato. He had also served on a number of national committees including the Steering Group for Health Reforms, the National Health Committee and the Nursing Council of New Zealand. He was appointed to the Board of the Health Funding Authority (The Māori Health Commission 1998b). Two of the six Māori Health Commissioners were Mr Rob Cooper, General Manager, Māori Health Division of the Health Funding Authority and Mr J Broughton. In 1998 the Board of the Health Funding Authority (1998b) identified eight Māori health gain priority areas for funding which were immunisation, hearing, smoking cessation, diabetes, asthma, mental health, injury prevention and oral health. The available evidence strongly suggests that the influence of Te Ao Mārama was instrumental in ensuring that oral health was included as one of these Māori health gain priority areas.

Te Ao Mārama became very proactive in having representation within the infrastructure of the dental health sector. Māori appointments to statutory bodies and professional organisations were discussed in Chapter 4. Māori participation in strategic forums continued throughout the latter part of the 1990s. Mr John Broughton
was a member of the Sector Reference Group established by the Ministry of Health for the development of the *New Zealand Health Strategy* released in December 2000 (King 2000a). Broughton was the only dental health professional invited to be a part of this Ministry of Health initiative, and was called upon by the New Zealand Dental Association to uphold its interests. The other Māori members of this Sector Reference Group were Professor Mason Durie, School of Māori Studies, Massey University and Ms Lynette Stewart of Te Tai Tokerau MAPO (Māori Purchasing Organisation). All three Māori members were emphatic that the eight Māori health gain priority areas were to remain as part of the New Zealand Health Strategy and this was the case. This strategic move ensured the Māori oral health was retained as a health priority. The eight Māori health gain priority areas were also included in *He Korowai Oranga*, The Māori Health Strategy.

Māori participation in the management of oral health services also occurred in the decade of the 1990s. Mr H Kaa was Senior Dental Officer attached to the Department of Health in Napier in 1986, and in 1990 became the Principal Dental Officer based in Gisborne managing the School Dental Service and public dental health for the Tai Rawhiti Area Health Board. Mrs Kay Poananga was the Dental Co-ordinator for the Eastern Bay School Dental Service in Whakatāne, and Mrs Anne Fogerty had this role in Southland. There were also a significant number of Māori school dental therapists, with at least 50 being members of Te Ao Mārama. In the field of dental education, Mr John Broughton is an academic staff member of the University of Otago Dental School whilst Mrs Helen Tane is the course convenor for dental therapy. At the Auckland University of Technology, Mrs Keita Tahana was appointed to the teaching staff for dental therapy. Although the numbers of Māori who were engaged in the management of dental services at this level was small, they were there.

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5 Personal communication, Dr L. Croxson, Executive Director of the New Zealand Dental Association.
Participation by Māori at all levels of the dental health sector is critical to ensure that Māori interests can be met through Māori influence. The Hon Tariana Turia, Associate Minister of Health speaking at the Hui-Ā-Tau (annual conference) of Te Ao Mārama in 2000 said, “we need to equip the sector with greater capacity to fill Māori needs much more effectively. This means that more effective and well trained personnel must be introduced rapidly to every level of the health sector.” (Turia 2000)

6.3.3 The development of the Māori dental health workforce

The first Māori to graduate in dentistry in New Zealand was Mr Walker Morete in 1920 (University of Otago 2004). He was followed by a very small number of Māori who entered the dental profession over the next three decades including Luke Rangi, Theo Kopae, Tiwha Bennett, Luxford Walker and Hector Steele (Durie 1998). In the post war era there was only a smattering of Māori entering the University of Otago Dental School as the majority of Māori students at Otago went to Medical School. Albert Kewene and Anthony Hikaka graduated in dentistry in the 1960s and Herbert Kaa in the 1970s. Dr A Kewene graduated Master of Dental Surgery (Periodontics) in 1974 becoming the first Māori dental specialist. It took three decades for the next Māori dental professional to qualify as a specialist⁶. By 1996 the active dentist workforce register revealed that out of a total of 1346 registered dentists, only six were Māori (0.4 per cent of the registered workforce) (Te Tau-Pringle 1997). The Māori dental health workforce has grown significantly over the last decade, with 33 Māori registered with the Dental Council of New Zealand in 2003. This will increase further in the near future with over 20 Māori students enrolled in dentistry at the University of Otago in 2006.

⁶ Dr Pauline Koopu, Master of Community Dentistry, 2005.
There has always been a substantial number of Māori school dental therapists. The New Zealand Dental Therapists’ Association has not kept ethnicity data on their membership but if the membership of Te Ao Mārama is used as a yardstick, then 10 per cent of the current dental therapy workforce may be of Māori descent.

Māori dental health educators became an important part of the Māori dental health workforce. In 1998, the Government made funding available through the Health Funding Authority for Māori, Pacific and rurally isolated 0-5-year-old children to access the School Dental Service. This was in part a response to the published data on ethnic differences in child oral health status (Thomson 1993). This funding was distributed throughout New Zealand on the basis of the number of Decile I schools in each area. As a result of this initiative, a number of providers who accessed this funding established Māori dental health educators. These were Māori health community workers who acted as the liaison between the dental profession and the community and were able to access kōhanga reo, kura kaupapa and whānau providing valuable oral health promotion, information and support. A working relationship developed between these new health promotion workers and the School Dental Service in particular.

6.3.4 Government policy

The Government policy is that the District Health Boards are required to purchase: free dental care for all pre-school, primary and intermediate school children; free dental care for teenagers up to their 18th birthday; emergency dental care for low income adults; basic dental care for people with special needs; and specialist hospital dental services. The poor oral health status of many Māori, especially young Māori, indicates that many Māori are not accessing publicly funded dental health services. Government has recognised this failure and with the participation of Māori concerted attempts are currently now being made to address the issues. This is occurring
through the adolescent dental health co-ordination schemes, promotion of fluoridation and funding for local authorities to cover the capital costs of fluoride implementation, Ministry of Health Māori Health Scholarships for dental students, and a slowly developing Māori oral health service provision.

Since 1990 the development and implementation of government policy for Māori oral health has occurred against a background of changing governments, health reforms and restructuring of the health service. Despite the dynamics of the health environment, the kaupapa of oranga niho was firmly established and has remained an important issue for Māori health gain. The health reforms under the Health and Disability Act (1992) provided the means by which Māori could access funding for the provision of services. However it was not until the National-New Zealand First Coalition Government of 1996 (which established the Māori Health Commission) that any direct headway was made with regard to oranga niho. The Māori Health Commission developed a concept for Maori oral health services (Māori Health Commission 1998a) that was included in the Budget of 1999. This was for a pilot programme (called Oranga Niho) which would provide integrated dental care. This initiative was able to survive the bureaucratic machinations of government departments and the Treasury bid process through the office of the Minister of Māori Affairs (The Hon. Tau Henare) who provided the support and the push for it in Cabinet.

The inclusion of oral health as one of the eight priorities for Māori health gain in both The New Zealand Health Strategy and He Korowai Oranga (The Māori Health Strategy) ensures that it remains a part of government policy. The report, Reducing Inequalities in Health underpinned a key government policy and J Broughton was a member of the Expert Advisory Group for this government policy (Ministry of Health
The development of a Toolkit to improve oral health was one of the outcomes of the Government's Reducing Inequalities policy (Ministry of Health 2004a).

One attempt that Māori made to influence government policy was a submission to the Select Committee for the Health Practitioners Competence Assurance Bill. Te Ao Mārama made a submission to the Select Committee for this Bill on 18 November 2002. Te Ao Mārama supported the intent of the Bill but wished to seek to include provision for the recognition of the Treaty of Waitangi. The submission sought the inclusion of an additional clause to Part 1 of the Bill with regard to the Purpose of the Act. Te Ao Mārama proposed (Te Ao Mārama 2002):

> This Act seeks to attain its principal purpose by providing among other things,-
> (a) for the acknowledgement of the special relationship between Māori and the Crown under the Treaty of Waitangi. Therefore, within the confines of the Act, there is the utmost good faith to ensure that the health and well being of Māori will be protected.

Te Ao Mārama based their submission on two premises. Firstly, that recognition was given to the Treaty of Waitangi in the New Zealand Health Strategy and this recognition should be articulated in the Bill. Secondly, reducing inequalities was a key policy of the Government and inclusion of this clause in the Bill would support that policy. When the Bill was finally passed by Parliament and became law there was no reference to the Treaty of Waitangi. However, Te Ao Mārama saw it as important that they had made an effort in trying to affect government policy. They were given a very fair hearing at the Select Committee and were applauded by the Health Select Committee Chairperson (Mrs Steve Chadwick) for having done so.
6.4 Māori Oral Health Service Provision

The provision of Māori oral health services for Māori communities began to intensify during the late 1990s. Dr Albert Kewene, a periodontist who had practised in Hamilton for 30 years made the call for “a marae-based dental clinic in the Waikato—so Māori can have their teeth checked for the price of a donation....a combination of "fear, money and the environment" is stopping many Māori families from attending mainstream clinics.” (Waikato Times 1996) Dr Kewene subsequently established a Māori dental service, at Tuhikaramea Medical Centre in Hamilton. There were a number of key Māori oral health services which developed throughout the country including the following:

6.4.1 Te Tai Tokerau (Northland)

The far north of the North Island had for many years been granted ‘special area’ status by the Department of Health because of the difficulty of providing health services in isolated rural areas. In the Hokianga by 1996, the school dental therapist was employed by Hauora Hokianga, a private trust but worked under the Principal Dental Officer of the Auckland Crown Health Enterprise. She was provided with a mobile dental equipment, and a dentist from Auckland came to the area once a month to provide dental care for adults (Tahere 1996). In Kawakawa, Hauora Whanui, a health initiative of the Ngāti Hine Health Trust is staffed by a school dental therapist who utilises “a mobile dental unit treating pregnant mothers, mothers with pre-schoolers and pupils at Bay of Islands College, Northland College and Ōkaihau College.” (Te Ao Mārama 1997c). However, despite these initiatives there remained what has been described as “an epidemic of dental decay in Northland”.

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7 National Radio Insight documentary broadcast 3 December 2000.
6.4.2 Ngāti Porou Hauora Dental Service, Te Puia Springs, East Coast

Ngāti Porou Hauora is an incorporated society of whānau, hapū and community which has been providing health services to the remote communities of the East Coast since 1994. It is based at Te Puia Springs and has five community health clinics on the East Coast and two clinics in Gisborne, each staffed by a multi-disciplinary team made up of doctors, nurses and non-clinical staff (Mitchell 2003). The Ngāti Porou Hauora Dental Service is based at the old Te Puia Springs Hospital and also provides dental services at the Ruatōria Community Health Clinic. It is staffed by a dentist, dental hygienist and support staff. They are able to make use of the mobile surgical service (for treatment provision under general anaesthesia) which visits the area approximately every five weeks.

6.4.3 Tipu Ora Trust, Rotorua

Tipu Ora is a mother and child wellness programme that was established at the Tūnohopū Health Centre, Ōhinemutu, Rotorua in 1990. The kaitiaki (Māori health community worker) provides support and advice for the child through their caregivers, parents and whānau, and acts as a facilitator between the child and their whānau and the relevant health, education and welfare services. The Tipu Ora Dental Clinic was opened on 9 June 1997 staffed by a school dental therapist to provide dental care for the pre-school children who were registered clients of Tipu Ora. The concept of a school dental therapist working with a Māori provider was not new as it already occurred with two Māori providers in Northland, but it was new for the Rotorua area. The Tipu Ora Dental service will be discussed at length in Chapter 8.

6.4.4 Western Iwi Health, Tauranga

In June 1998, Western Bay Health and Health Services commissioned a review of their community dental service which was undertaken by Dr Clive Wright (Wright
Following the release of the report a *hui* was held in Tauranga\(^8\) to discuss the way forward. The Manager for the School Dental Service\(^9\) reported that the 1996 Census had revealed that there were 2,500 Māori pre-school children within the Western Bay area but only 600 were enrolled with the School Dental Service. The suggestion was made to place a school dental therapist with a Māori provider to provide dental care for the large number of Māori pre-school children who were not accessing any dental care services. This proposal was implemented and Western Iwi Health was renamed Te Manu Toroa with a *kaupapa Māori* dental service being established in 1999 (McGibbon 2001).

### 6.4.5 Tūranga Health, Gisborne

One Mobile Dental Unit RNZDC provided a civilian exercise in partnership with the Tūranga Health, a Māori provider in Gisborne from 7-18 February 1999. The mobile dental surgeries were located at three sites, an urban situation and two *marae*. A total of 1419 people had registered for dental treatment but only 641 were able to be seen in a total of 873 patient appointments (Tūranga Health 1999). A lack of effective liaison between the army dental personnel and the Māori provider resulted in failure to record a meaningful data base of the patient group. An intended outcome for the Māori provider was to have an accurate dental profile of their client base but the nature of the “database structures and inputting procedures” did not allow this to happen. However, those people who were fortunate to access this limited one-off dental service were indeed very grateful. One patient said, “I thought the service was great, especially for me as a single mum, my baby was looked after during my appointment and I got a service provided that I would not otherwise due to cost. Location at the *marae* was excellent, relaxed environment, [I] didn’t feel *whakamā*.”

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\(^8\) 3 September 1998. *Hui* hosted by Ngāti Ranginui ā Iwi, Tauranga.

\(^9\) Personal communication, Ms Sharon McKoy Thomas, Dental Therapy Manager, Western Bay Health and Health Services, Tauranga 3 September 1998.
This project identified a high unmet dental health need among the Māori community of the Gisborne area. Turanga Health was resolved to “pursue the establishment of a dental service.”

6.4.6 Te Ātiawa Dental Service, New Plymouth

Dr Tony Ruakere (a general medical practitioner) established a Māori medical practice in New Plymouth under the auspices of the local īwi, Te Ātiawa Runanga Medical Trust in the 1990s (Ruakere 1998). He found that many of his Māori patients had severe dental problems and little likelihood of accessing any definitive dental care. To address the concerns, he was able to obtain the support and enthusiasm of local dentist Dr Chris Taylor to establish Te Ātiawa Dental Service. The clinic opened on 22 March 1999 for two days a week and aimed to provide a full range of dental services for whānau. The need for an appropriate, affordable and accessible dental service for Māori was identified and, with a considerable amount of background work, a dental service as part of a Māori health provider was established to meet the unmet dental health needs of the predominantly Māori client base. This clinic will be discussed in detail in chapter 9.

6.4.7 Te Taiwhenua O Heretaunga, Hastings

Te Taiwhenua O Heretaunga is a major Māori provider of health and disability and social services in Hastings. It was awarded a major contract for a new oranga niho integrated dental care project. This came about through the efforts of the Māori Health Commission, who had devised a programme to meet the dental health needs of Māori which involved a dentist and a dental therapist working together as part of an existing Māori health provider. The proposal Oranga niho Māori: A Plan For Action was presented to the Minister of Māori Affairs on 10 November 1998 (Maori Health Commission 1998a). He was very supportive of this plan and ensured its passage
through the Treasury Bid process and its inclusion in the Budget of 1999. The Ministry of Health awarded the contract on the basis of four criteria: a high Māori population; a high unmet dental need; a preferred provider with an existing general medical practitioner service; and where there had not previously been any Māori specific dental health projects. The provider service identified was Te Taiwhenua O Heretaunga in Flaxmere, Hastings. The service opened on 1 April 2001 with a dentist and chair-side assistant providing integrated, whānau-based oral health services to children and adolescents, and emergency care to low-income adults. A school dental therapist was appointed soon after. The piloting of this integrated, whānau-based oral health service aimed to test the potential of a new model of oral health service delivery in order to reduce the disparities in oral health status experienced by Māori compared to Pākehā.

6.4.8 Te Whare Kaitiaki, Dunedin
This service, based within the University of Otago Dental School, was established in 1990. It is a teaching clinic for final-year dental students and is funded in the main through the teaching budget. A small additional amount of funding comes from the contract the Dental School has with the Otago District Health Board. The service is available for Māori people and their whānau, although many other people have chosen to seek treatment at this clinic. The clinic operates on a Tuesday morning during the academic year with two final year students being rostered to the clinic each week. This clinic is discussed in detail in chapter 10.

6.5 Oranga niho Education
This is the third strand in the whakapapa of oranga niho as a distinct Māori health entity. During the 1990s, there was a small but significant development of Māori
specific oral health education resources. They will be discussed in detail in Chapter 12. The unfortunate reality is that the dental profession was not proactive in ensuring that its dental health messages were communicated effectively to Māori. This was not out of the ordinary as there had been a ‘one-size-fits-all’ approach by the health sector which was epitomised in a comment by the National Cot Death Association National Co-ordinator who rejected the idea of a SIDS prevention programme designed for and by Māori (Tonkin 1996):

My own feeling is that we are all New Zealanders and I think it’s extremely difficult to direct information to just one group of people. We all read the same newspapers and watch the same TV.

Māori, however, rejected such comments and became more resolved to develop appropriate health promotion resources that were ‘by Māori for Māori’. A number of innovative resources and activities have been developed since 1994 to promote oranga niho to Māori communities including printed material, waiata (songs), brush-in programmes in schools and kōhanga reo, and active participation in Māori health days and expositions. They are all significant as they were designed and produced by Māori for a predominantly Māori audience. They are an important part of the whakapapa of oranga niho as they represent tangible items that reflect positive messages about oral health for Māori. They are discussed in detail in chapter 12.

6.6 Te Whakamutunga (The Conclusion)

Oranga niho is now a well established and recognised Māori health entity in its own right. As a health concept, it evolved and developed throughout the decade of the 1990s to the present time with its own whakapapa. It has its own history and its own identity. This has come about through the weaving together of three distinct strands,
Māori oral health strategies, Māori oral health services and Māori oral health promotion. The underlying aspect of this woven strand is *tino rangatiratanga* or Māori self-determination. The weaving together of this strand has only just begun and the full extent of the progress and achievements has yet to be realised.
Chapter 7

Whakawhānuitanga

(Diversity)

7.1 Māori Health Development

Ryan (1974) translates the word ‘whānui’ to mean ‘broad’ or “wide’. The prefix ‘whaka’ to a word gives meaning of ‘to do’ or ‘cause to do’ that particular action. Mead (2003) defines ‘whānuitanga’ in the context of research as “expanding knowledge outwards.” If whakawhānuitanga as a research principle is applied to Māori development (which in turn is the betterment of Māori through Māori ability to contribute effectively, and to respond appropriately, to the ever changing dynamics of contemporary society) then whakawhānuitanga has connotations of diversity. Whakawhānuitanga therefore, is concerned with recognising and catering for the diverse needs and aspirations of Māori individuals and collectives. Love (1998) in a keynote address at Te Oru Rangahau, the Māori Research and Development Conference at Massey University presented a description of Māori development:

One suggestion is that it means improving the well-being of Māori across a broad range of social and economic measures. Māori development must also address a number of fundamental issues and/or principles, (including):

* being able to improve the quality of life for Māori, and in doing so for all New Zealanders;

* allowing Māori as Tangata Whenua to take a proper stake in the affairs of New Zealand - in keeping with the Treaty of Waitangi; and

* enhancing the ability of iwi and hapū and Māori to make choices and to develop our cultures in ways which reflect modern times.
This description illustrates the application of whakawhānuitanga to Māori development which encompasses a diversity of approaches, methodologies and structures, yet has the unified goal of the improvement of Māori health. Love also identified a number of critical factors which he considered should be taken into consideration for effective and appropriate Māori health development. These included:

* The need to increase Māori capacity, our capabilities as a people;
* communities should be able to choose various collective paths of development, i.e. self determination; and
* a recognition of the Treaty of Waitangi in Māori development.

The need to increase Māori capacity and capabilities is essential for the development of Māori health services. This can be accomplished through both the enhancement of the collective abilities and expertise of Māori, and their acquisition of technical, scientific and health sector knowledge and qualifications. That “communities should be able to choose various collective paths of development” is an expected outcome following the application of the principle of whānuitanga. For this to happen, there is the requirement for the evolution of a diversity of Māori health services, or a Māori health provider which delivers a diverse range of health services. A Treaty of Waitangi framework is an appropriate pathway for these things to happen.

Māori health services are an integral part of Māori health development and Māori oral health services are a health service that Māori are seeking to deliver. That it took so long for Māori health services to evolve was not due to a lack of willingness on the part of Māori; it was State control. The Welfare State policies introduced by the Labour Government in 1935 saw a heavy dependence upon the ‘State to provide’. The impact of State control on the delivery of dental health services was denounced as long ago as 1950 by Gruebbel (1950) who stated that:
...political, cultural and economic consequences of socialism are strikingly evident in New Zealand. Excessive social legislation has greatly increased the power of central government and has lessened individual freedoms; it has encouraged mediocrity and has stifled the urge to excel; it has discouraged personal initiative and has caused heavy dependency on the State for individual needs....

Mr Wira Gardiner, Chief Executive of Te Puni Kokiri, stated that, "from the beginning of the development of public health services in New Zealand, Māori have wanted to develop their own health services" (Cited in Te Puni Kökiri 1994b). He identified the lack of financial resources available from purchasers as the major barrier which impeded the development of Māori health services which in turn limited severely Māori choice of service. In the half century since Greubbel's comments there has been a very significant shift in health service policy, structures and processes resulting in decentralisation, the advent of District Health Boards, and an allocation of funding for the development and provision of Māori health services. Although Māori health services are publicly funded, there is Māori autonomy over their implementation, management and operation.

7.2 Māori Health Services

Durie (1989) identified partnership and participation as being significant principles in any consideration of Māori health services. When he included the Treaty of Waitangi in the discussion, three areas of application were pertinent: firstly, partnership and participation in understanding health and sickness; secondly, partnership and participation in the development of health policy; and thirdly, partnership and participation in the delivery of health services. In order to achieve positive health gains for Māori, Durie concluded that “there are some services which might be better provided by Māori organisations in their own way.”
Durie (1998) makes a distinction between a Māori health service and a mainstream health service which includes a Māori perspective, even though the distinguishing characteristics of the former are not always well defined. Using health objectives rather than political objectives, Durie has identified four essential characteristics of a Māori health service: firstly, clinical inputs which are consistent with the best possible outcomes; secondly, a cultural context which makes sense to clients and their whānau; thirdly, outcome measures which are similarly client-focused; and fourthly, the integration of health services with other aspects of positive Māori development. The application of these four characteristics can be illustrated as follows:

(i) Clinical inputs which are consistent with the best possible outcomes.
   The development of best practice guidelines for Māori and their whānau such that cultural considerations need not be sacrificed for clinical excellence.

(ii) A cultural context which makes sense to clients and their whānau.
    This is concerned with the identification of the important cultural inputs which are appropriate for Māori clients such as actual activities and relevance for a particular circumstance.

(iii) Outcome measures which are similarly client-focused.
    For many Māori patients, best outcomes should be considered in a socio-cultural context, such as the domains of outcome (taha wairua, taha hinengaro, taha tinana and taha whānau).

(iv) The integration of health services with other aspects of positive Māori development.
    This is concerned with an inter-sectoral approach which encompasses not only cultural aspects but also social and economic factors.
The application of these principles of partnership and participation together with the particular characteristics of a Māori health service has resulted in an increasing diversity in the provision of Māori health services.

7.2.1 The diversity of Māori health services

There are essentially three models of a Māori health service:

(i) Those Māori health services that are based within a mainstream service or organisations. This then gives that mainstream service a Māori perspective. For example, Te Oranga Tonu Tanga, (a Māori mental health service) and Te Waka Hauora (a Māori health promotion service) both provide Māori health services within HealthCare Otago.

(ii) Those providers that are iwi or community based. For example, Aranteuru Whare Hauora and Te Ropū Tautoko Ki Te Tai Tonga are Māori community based health services in Dunedin

(iii) Those providers that are in partnership with another service or organisation. For example, Te Mauri-A-Iwi, a Māori provider in Masterton established a partnership with Plunket in 1999 and were successful in gaining the contract for Tamariki Ora Wellness programme in the Wairarapa.

In 1992, the National Advisory Committee on Core Health and Disability Support Services recommended that there should be an assurance “that primary care for Māori is effective, available, and provided in forms that encourage use by Māori for health maintenance, health promotion and for early use early in disease” (Durie 1998). The key point of this recommendation is the phrase “provided in forms that encourage use by Māori.” Māori as a group are just as diverse as any population group and will
naturally choose a particular health service that is appropriate for them. On the other hand, some Māori may choose not to access a health service at all. Other factors being equal, a kaupapa Māori service is more likely to attract Māori clientele and their whānau, particularly if they have not otherwise accessed a service.

At the Human Rights Commission Hui Mana Tangata on Māori participation in the delivery of health services, Durie referred to the decade of the 1990s as one of “Māori enterprise” (Durie 1993). The Health reforms and the purchaser provider split enabled Māori to access resources and funding which resulted in a dramatic increase in Māori utilisation of health care. There are now 240 Māori providers with DHB contracts. However, there is no one blanket model for Māori health service provision. The structure and organisation of a Māori health service is based on the uniqueness of the social and political constructs of each particular area in which that service is located, and the relationships that have developed within the health sector, with whānau, hapū and iwi Māori, and with the wider community. Māori health services have developed within their respective communities to attempt to meet the health needs of their communities in their own particular way. As such, it is very dynamic entity with a requirement to adjust and adapt to the ever changing health sector environment. Wright referred to the “package” of dental services which must be constructed to meet community and national needs (Wright 2000). He stated that “there is no single simple solution; it is an equation of elements which vary from marae to marae, district to district, and region to region.”

One recognised solution however, is the diversity of health services that a Māori provider may provide. Broughton (2000b) discussed the merits of a Māori oral health service working as part of an existing Māori provider service because it has:

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• an administrative infrastructure already in place;
• an established client base;
• networks and communication strategies;
• existing Māori health community workers who are part of the team;
• medical back-up and support available; and
• integration with other health service components.

Not only have a diversity of Māori health services evolved, there are a diversity of services that a single Māori provider may provide. The availability of choice is an important factor in the empowerment of Māori to access health services.

### 7.2.2 The need for Māori oral health services

It is widely recognised that all New Zealanders do not have universal access to oral health services. This is a complex issue which has been due to such factors as affordability, acceptability and accessibility of services, and a lack of knowledge about the availability of services (Broughton 1993b). Māori are just one group within the New Zealand population whose utilisation of oral health services is poor. Other groups include preschool children, adolescents, Pacific peoples, people from low socio-economic groups, people with psychiatric or intellectual disabilities and new migrants (Ministry of Health 2004b). There have been a number of references in the literature, especially over the last two decades, which demonstrate a lack of utilisation of oral health services by Māori. This would explain, in part, the poor oral health status of Māori. This failure by the traditionally accepted forms of dental health service provision to meet the dental health needs of Māori has been one of the driving forces behind Māori development of Māori oral health services. A hīkoi (journey) through this literature reveals some interesting documented observations.

The Beaglehole survey of the Māori community of Kōwhai in the 1940s included particular references to Māori responsiveness to dental health care (Beaglehole 1946):
For aching or diseased teeth, the older people recommend immediate extraction (that is, if one can afford it at 5/- a tooth). The younger people prefer to try various nerve killers and other medicinal applications before going to the dentist. So-called painless dentistry does not appeal to the old people. The prick of the needle injecting the local anaesthetic is something which they fear before the event, dread at the time and have nightmares about afterwards.

The school dental nurse, however, reports that Māori children are among her best patients at the school clinic. They are stolid in the dental chair and patient, bearing pain without whimpering and crying out. From this point of view they are superior to Pākehā children. Out of a total number of 380 child patients of the clinic, the Māori children number 68. The figure represents about three-quarters of the Māori children who should be attending. The remaining Māori children are not treated at the clinic because their parents are regarded as having refused consent to treatment. This is presumed after the parents have failed to reply to three cards – two carried by the child and one by post. Little attempt seems to be made to interview the parents with a view to explaining the value of dental treatment. This incidentally seems to be a job that could very well be more systematically carried out by one of the school officers or the district health nurse so that Māori children will not be penalised through indifference, casualness, or lack of knowledge on the part of their parents.

Although this report alludes to a lack of responsibility on behalf of the patient and their family (victim blaming) it also indicates a failure on behalf of the dental health service with regard to the administration and enrolment procedures. In addition, no thought was given to the possibility that there could be issues of actual service delivery.

The plight of Māori oral health was alluded to in the 1978 Report of The Dental Health Workshop without any actual reference to Māori. Two specific ‘at risk’ population sub-groups were described as “lower socio-economic” and “racial groups”
(Department of Health 1978). It is obvious that Māori would be included in these two groups, particularly the “racial groups”. The report stated:

Within the adult population attitudes to oral health did not vary greatly between socio-economic and racial groups. However, utilisation of dental services was found to vary greatly, being much lower by people in the lower socio-economic groups. There was a trend also, for the lower socio-economic groups to be more fatalistic about eventual tooth loss.

The Workshop recommended that “target groups, consisting of those who are particularly at risk should be identified, and specific programmes developed.” It would not have been difficult for the Workshop to have actually identified these ‘at risk’ groups. However, the recommendation that specific programmes should be developed for the ‘at risk’ groups was to provide the potential for future development. That it took over a decade for any specific oral health programmes to be developed for Māori (as one of the identified ‘at risk’ groups) highlighted that, in retrospect, this recommendation was probably ahead of its time.

In 1982 the Christchurch Child Development Study reported that “just under one child in six failed to receive dental care by the age of four years...However, the results do underline the fact that even with a free and comprehensive preventive programme, a sizable minority of children fail to receive dental care” (Beautrais et al. 1982). The study found a “clear and highly significant association between the child’s social background (which included ethnic status) and the rate of utilisation of dental care, with children from socially disadvantaged backgrounds being at greater risk of not receiving care.” This study did not undertake a breakdown of ethnicity except to report on differences between ‘Caucasian’ and ‘non-Caucasian’ groups. The
results of this study point to a failure of the traditional dental health services meeting the dental health needs of the ‘non-Caucasian’ group.

In 1984, Hunter reported a similar finding to the Christchurch Study in that fifty-five per cent of European children were enrolled in the School Dental service by 3 years of age compared to 22 per cent of non-Europeans (Hunter 1984). Where Beautrais had referred to ‘non-Caucasians’, Hunter referred to ‘non-Europeans’. Beautrais had also reported that the pre-school children who did not receive dental care shared a number of social disadvantages including non-utilisation of other forms of child care. Hunter commented that “if this pattern is typical of the whole country, then increasing preschool enrolment for dental care would appear to be difficult if attempted in isolation from other aspects of health care.” This latter comment by Hunter was quite pertinent to kaupapa Māori health services but any implications for action were not realised, let alone undertaken, at that time.

In 1988 de Liefde reported on dental care in the Dental Benefit Scheme. She found that by their sixteenth birthdays, 78 per cent of European children were receiving treatment, compared to 45 per cent of Māori and ‘other’ children (de Liefde 1988). de Liefde concluded that because there was a low enrolment of Māori in the Dental Benefit Scheme and a drop out rate that was double that of European, then “there was obviously a need to investigate the reasons for these differences and for public health administrators and private practitioners to examine attitudes and procedures.” Clearly, there was a need for a re-orientation of dental health services to ensure that there would be an improvement in utilisation by those who were missing out.

Ross in a review of New Zealand dental traditions described the history of New Zealand dentistry up to the 1970s as being one of “the provision of treatment services to meet a large backlog of untreated disease” (Ross 1984). In 1950, 42 per cent of the
adult population in the 34-44 age group were edentulous; in 1976, it was 28 per cent; and in 1982, it was 16 per cent. New Zealand adults in the post-war era were retaining their teeth longer. However, despite this improvement in oral health status, Māori, Pacific peoples and the socio-economically disadvantaged continued to have poor oral health status in comparison to the total population. Ross proposed that a re-evaluation of delivery of services in New Zealand was necessary which must include “special attention” being paid to those disadvantaged groups.

Although the decade of the 1990s saw the beginnings of Māori oral health services, their development was slow and limited. The issue of poor access to dental services by ‘at risk’ groups within the New Zealand population continued to be raised. In 1996, Broughton and Koopu reported that in the Rotorua area 27.5 per cent of Māori teenagers did not access dental care under the Dental Benefit Scheme, increasing to 72.2 per cent who did have any regular dental care after leaving school (Broughton and Koopu 1996). In 1998, Hannah commented that “The issue of access for Māori to dental health services continues to cause concern” (Hannah 1998).

In 1999 Dixon reported on the use of dental services on the West Coast (Dixon et al. 1999). The finding was an infrequent use of dental services by the lower socio-economic group. The researchers acknowledged that a shortcoming of the study was that “Māori were not sampled other than those who were on the West Coast-Tasman Electoral Roll.” They recognised this as a legitimate concern, “but the principle of tino rangatiratanga dictates that Māori health research be conducted by and for Māori.”

Wright, in his keynote address to the Oral Health Forum 2000 said, “If the New Zealand oral health system is broken, that is, it is not reaching and meeting at least the needs of the community, let alone their wants and demands, we have to look at ways
to fix it” (Wright 2000). He posed the question, “How central are Māori health
providers and a well-developed, but integrated, Māori oral health service to improving
access to dental services?”

The Minister of Health, The Hon. A King speaking at the opening of the New Zealand
Dental Association conference in 2000 stated, “One key oral health policy goal that
has already been identified is to improve, promote and protect the oral health of New
Zealanders. In order to meet its objectives for the oral health sector, the Government
has identified six key initiatives. One is to investigate greater access to dental care for
low-income adults” (King 2000d).

At the Oral Health Forum 2000 Whyman discussed the delivery of oral health
services (Whyman 2000). He made a number of proposals which would sit very
comfortably with Māori provision of Māori oral health services. He proposed that:

- Pre- and primary-school dental services need to be redeveloped, with less
  emphasis on a school base for much of the dental care. A redeveloped system
  should incorporate dentists working alongside dental therapists, and the
development of larger, community-based clinics to cater for some treatment
  needs of young children;
- Adolescent dental services should focus on establishing healthy behaviour
  including dental attendance, rather than simply treatment provision; and
- Innovation in the development of dental service delivery systems should include
  development of a “dental team” approach to care, and integration of dental
  providers within the framework of primary health care providers.

These proposals would make significant inroads into the improvement of Māori access
to oral health services if they were implemented and managed under the umbrella of a
Māori provider organization.
7.2.3 Reducing inequalities and oral health services

Reducing inequalities in health is a key policy of the Government. The Ministry of Health recognised that "there is enormous scope for reducing inequalities in oral health" (Ministry of Health: undated 'Fact Sheet'). One way of achieving this was the provision of health services which would not only eliminate inequalities of access, but also eliminate inequalities in the type of treatment different people receive once they are within a service. The Ministry of Health identified a number of specific actions that could be taken within oral health care services:

- providing oral health education and enrolment with the School Dental Service at 12 months of age as part of the well Child programme;
- investing in Māori oral health workforce development;
- increasing the amount of time medical students spend on dentistry;
- ensuring that primary health organisations have an integrated dental health component;
- funding regional co-ordination positions to increase the numbers of adolescents receiving regular dental care as well as to improve the quality of the service;
- reorienting the School Dental Service to promote oral health more strongly, in addition to repairing damage; and
- developing national oral health education resources that are suitable for Māori.

The establishment of Māori oral health services which are community based or iwi based, and sit either alongside or as part of an existing Māori health provider, would result in most of these proposed actions being effectively undertaken, and facilitate the desired outcome of a reduction in oral health inequalities.

7.2.4 The diversity of Māori oral health services

Māori have advocated for Māori oral health services to be delivered in a team approach (whanaungatanga) consisting of a dentist and dental therapist working
together as part of a Māori health provider (Māori Health Commission 1998a). However, Whyman has doubts about the efficacy of a dental team and questions if this is the team to improve oral health (Whyman 2000). He based his doubts firstly, on the effectiveness of combining dental service-delivery providers; secondly, on the competitiveness between the different providers that might arise rather than being complementary to one another; and thirdly, on the remuneration expectations of the different team members. Māori would reject these doubts altogether on the basis that the very essence of kaupapa Māori services is a team approach. Māori have always functioned on the basis of collectiveness, taking strength from the combined talents and contributions of each person. Māori health providers in a particular region tend to be complimentary in their service provision rather than trying to function in a competitive environment. Tui Ora in Taranaki is an example of providers working co-operatively (Tui Ora 1999). Tui Ora is “an integrated health service organization committed to enhancing health and wellbeing which evolved from a dedicated 4-year joint venture relationship between the Taranaki Iwi Health Forum, Te Whare Punanga Korero Trust, and the former Midland RHA. With the emergence of Tui Ora and the majority of Māori providers uniting under this umbrella there is greater synergy, to work co-operatively and to work “smarter” with all providers, in delivering integrated services to consumers.”

When dental health services that are currently available are set against the Māori life cycle (mokopuna, tamariki, rangatahi, pakeke and kaumātua), the strict demarcations between one group and the next are evident (Figure 7.1)
Figure 7.1 Dental health services and Māori life cycle

<table>
<thead>
<tr>
<th>Mokopuna</th>
<th>Tamariki</th>
<th>Rangatahi</th>
<th>Pakeke</th>
<th>Kaumātua</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publicly funded: School Dental Service</td>
<td>Publicly funded: Dental Benefit Scheme</td>
<td>Privately funded: Fee for service</td>
<td>Limited public funding for low-income adults (WINZ)</td>
<td></td>
</tr>
</tbody>
</table>

An entry and exit process is required for each type of dental care as the individual moves from one age group to the next. Māori prefer a service that is seamless, catering for the whole whānau from mokopuna through to kaumātua. Under the current publicly funded system there is a clear demarcation of services that are available for each age group within the population. Māori prefer a ‘one-stop shop’ which is all inclusive and can therefore cater for everyone.

In 2004 there were 15 Māori oral health providers with DHB contracts. They were:

- Ngāti Whātua o Īräkei Health Services
- Tipu Ora
- Te Manu Tōroa
- Te Whānau o Waipareira
- Te Atiawa Dental Services
- Ngāti Porou Hauora
- Tūranga Health
- Hauora Whānui
- Kahungunu Executive
- Kahungunu Health Services
- Te Taiwhenua o Heretaunga
- Te Kohao Ltd
- Glen Innes
- Rotorua
- Tauranga
- West Auckland
- New Plymouth
- Te Puia Springs
- Gisborne
- Kawakawa
- Wairau
- Hastings
- Hastings
- Hamilton

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2 Personal communication, C Makowharemahihi, Maori Health Directorate, Ministry of Health, Wellington. 10 June 2004.
These services are quite different, with different health provider infra-structures and relationships serving different communities. The diversity of these services was questioned in the *Review of Publicly Funded Oral Health Care in New Zealand* in 2001 which stated, “while the range of specific Māori programs is laudable, there should also be opportunity for health workers and the community to review the merits and applicability of the initiatives and determine the appropriateness of such programs in other settings” (Ministry of Health 2001). The recommendation was made that approximately 25 per cent of the national oral health budget be quarantined for a ‘risk-pool’ and a ‘special incentives pool’ to be bid for on the basis of demonstrated special need, with target groups especially including: firstly, Māori and Pacific communities; secondly, children from low-income families; and thirdly, high need/high risk individuals (note these are not mutually exclusive groups). A review of Māori child oral health services was undertaken by the Ministry of Health in 2004 which highlighted the diverse nature of Māori oral health service delivery.

Three models of Māori oral health service provision are reviewed in this thesis. Each service has a different contractual relationships with their provider organization. The three services are:

(i) Tipu Ora Dental Service, Rotorua.

This service is in partnership with the School Dental Service, Lakeland Health.

(ii) Te Ātiawa Dental Service, New Plymouth.

This service is part of an Īwi-based provider, Te Atiawa Medical Service.
The aim of this thesis is to review Māori oral health services using these three services mentioned above with regard to their development, implementation and operation. The following three chapters will examine each of these three particular Māori oral health services in detail.

7.3 Te Kōrero (The Discussion)

Māori have had unacceptably poor access to oral health services. Despite the publicly funded School Dental Service and the Dental Benefit Scheme, both preschool Māori children and Māori adolescents (in particular) have under-utilised these services. For adults, publicly funded dentistry (apart from some specialist hospital services) only caters for specific dental treatment services for the low-income group. The few Māori health services that have evolved and developed since the early 1990s have proven their worth with a resultant increase in Māori access to dental care. Māori have subsequently been seeking the development of health services including oral health services, with a structure and organization that is commensurate with their particular social environment and is responsive to the needs of the local community. The outcome of this development, from a global perspective is diversity, with a range of Māori oral health services being established based on the uniqueness of the various communities which they serve.
Chapter 8

The partnership model: Tipu Ora Dental Service

8.1 Ngā Timatanga (The Beginnings)

Tipu Ora is a mother and child wellness service that was established in Rotorua in 1990 following a successful pilot programme. The health and welfare of mothers and their babies had been an ongoing concern for Māori communities for decades. In the 1920s Miss Robina T. Cameron, a district nurse based in Ōpotiki, worked up and down the East Coast where her interest and concern for Māori welfare began (National Register of Archives and Manuscripts). In 1931 she transferred to Rotorua where she was confronted by high Māori infant mortality and maternal mortality rates as well as high rates of tuberculosis and other infectious diseases (Durie, 1998). She established local health committees to address these concerns and in 1937 they came together at the Tūnohopū Marae to form the Women’s Health League. This organization (also called Te Rōpū O Te Ora) had very strong Māori support throughout the Te Arawa region. In August 1986 the Tūnohopū Health Centre was opened at Ohinemutu by the Women’s Health League and was dedicated to Nurse Cameron.

Mrs Inez Kingi: To build the Tūnohopū Health Centre, Pihopa (Kingi) gave the land for the centre and most of the money was gifted from the Women’s Health League.

In 1990 at the Hui Hauora Mokopuna (Māori Child Health Conference) which had the kaupapa of developing strategies to improve the health of Māori preschool children, a plan was put forward by Dr Jacqueline Allen and Mrs Inez Kingi for a Māori child...
health care network (Allen and Kingi 1990). Mrs Inez Kingi who worked as a school
dental nurse since 1952 was a loyal and faithful member and supporter of the
Women’s Health League. The Tipu Ora philosophy was for “our babies to grow up
being Māori and healthy”. This plan was developed in response to both poor Māori
child health statistics (Pōmare et al. 1988) and an acknowledged lack of use of
community nursing services by Māori people in Rotorua. The main thrust of the new
initiative was to have kaitiaki (care person), an experienced grandmother, who would
be taught the relevant medical needs pertaining to child health. Tipu Ora was not
perceived to be “an alternative to Plunket or to the Public Health Nurses,” but to
provide much needed services to those mothers who “fall between the cracks”, and to
those parents who were not accessing any health services and who were consequently
contributing to poor health statistics. The inception of Tipu Ora was a response to the
worsening state of child health in the Waiairiki region aided by the community’s long
history with the Women’s Health League.

Mrs Inez Kingi:  
In 1985 when I was working on the Māori Health Workforce Development Komiti for the Ministry of Health I realised that something could be done by promoting a Māori workforce to promote health and well being in the home.

Mr Pihopa Kingi:  
The vision was created by Inez Kingi and Dr Jacqui Allen using the kaupapa of the Women’s Health League.

Mrs Inez Kingi:  
The whole concept of Tipu Ora was developed in 1987 and by 1990 it was up and working. The pilot was funded by the Department of Health through the Workforce Development Programme.
Mr Pihopa Kingi: The kaupapa for our tamariki and their whānau was to be healthy and Māori.

Mrs Inez Kingi: The name ‘Tipu Ora’ came from Pihopa. He gave us our name. It means to grow a healthy young shoot.

The plan became a reality when a contract was made with the then Department of Health for a pilot programme (Ministry of Health 1998).

Mrs Inez Kingi We were fighting and fighting to get our voice heard. We (Pihopa and I) were part of the Eastern Māori National Party. Simon Upton was the Minister of Health so we thought, ‘why don’t we go and see him?’ We did just that and he looked at our proposal. I have to say that when we met him, I was wearing a red coat; I should have had a blue one!

Mr Pihopa Kingi: We had to convince the Minister of Health of the viability of Tipu Ora. He had to find the funding. It was primarily funded through the system. He had the courage to be able to divert funding from Plunket who had always reigned supreme over child health care.

Mrs Inez Kingi: The Minister said, “Send me some more papers (that is details about your proposal) and mark it for my eyes only”.

We did that and within two weeks we had a letter from him with the funding for a pilot for six months.
Following the successful completion of this six-month pilot in 1990-91, ongoing funding was obtained through the Bay of Plenty Area Health Board in 1992, and in 1993, the service contracts were picked up by the newly established Midland Regional Health Authority.

Mr Pihopa Kingi: A key factor in the development of Tipu Ora was the Government. In 1991 under a National Government Simon Upton was appointed Minister of Health. He introduced contestability; the purchaser/provider split. We could now access funding which couldn’t happen before. Politics was a problem as there was a political barrier. We had to overcome that to access funding and this contestability was very timely.

The contract was for the delivery of health care programmes for Maori caregivers and their children, from the babies’ conception until they turned five. Antenatal services included preparation for birth, facilitating hospital visits, educating families on smokefree environments and assisting in the provision of midwifery and other support services. Post-natal support included recognising and preventing childhood illnesses, nutrition and health promotion. Well-child checks and vaccines were provided at six weeks, three, five, seven and eighteen months, with a dental check at two years.

Mrs Inez Kingi: Dr Jacqueline Allan put the programme together. She was the Medical Advisor and was responsible for the training of the kaitiaki. We selected six kaitiaki who underwent a training programme. The kaitiaki had to be a non-smoking young grand mother.
Tipu Ora was formally established in 1990 becoming a certified Charitable Trust on 27 April 1992 under the Charitable Trusts Act (1957). The six original trustees were Bishop Manu Bennet, Dr Jacqueline Allan, Mr Leith Comer, Mr Pihopa Kingi, Mrs Inez Kingi and Mrs Putiputi O’Brien (Tipu Ora 2003). Since then many trustees had “come and gone” and in 2003 the Trust has been “revamped” with new trustees, whilst still retaining three of the original Trust Board members.

Mr Pihopa Kingi:  
*The service was very closely monitored because we were Māori.*

Mrs Inez Kingi:  
*Then we had a 12-month contract and we were away. That’s when I could employ an administrator.*

Mr Pihopa Kingi:  
*Leith Comer was our first Administration Officer. He is now the Chief Executive Officer for Te Puni Kōkiri.*

Mrs Inez Kingi:  
*By the time of the Māori Health Decade hui in 1994 we were well established.*

The key to Tipu Ora’s success were the iwi-approved kaitiaki. The kaupapa of using kaitiaki to deliver services had come from the traditional system of older people teaching life skills to younger people. The kaitiaki provided a trusted link between whānau and the broad range of specialists from both Māori and mainstream providers whom Tipu Ora depended on to provide an integrated multi-dimensional service to their clients.

Between 1992 and 1998 Tipu Ora had registered approximately 4,000 clients which accounted for 60 per cent of all Māori babies within their geographic region.
Mrs Inez Kingi: *There was a high cot death rate in Rotorua. I said, in my mind that we would lower that at once.*

Between 1992 and 1994, the Māori infant death rate from Sudden Infant Death Syndrome (SIDS) was 4.5 times the non-Māori rate for the whole country. While the non-Māori SIDS rate decreased by 62 per cent between 1985 and 1994, over the same period the Māori rate decreased by only 13 per cent, resulting in the gap widening between Māori and non-Māori SIDS rates (Ministry of Health 1998). Between 1992 and 1996, there were 52 deaths by SIDS in the Tipu Ora region; 46 were Māori, but only three were Tipu Ora babies (Ministry of Health 1998).

Mrs Inez Kingi; *We lowered the cot death rate by two-thirds. That was in my first 3-month report and the same thing was in my 6-month report. That was the evidence (of our impact) and then we were away.*

*The messages were: don’t sleep with baby; don’t sleep drunk with baby; make a bed for baby, make baby a bed in a drawer or on a pillow.*

*We promoted breast feeding.*

*Getting parents off drugs that was another thing; we moved around their addiction. If we slammed them they wouldn’t let us back. We got to dad first and that approach worked.*

The Tipu Ora model rapidly became a well known Māori provider service delivering a holistic well child care programme which focused specifically on delivering health care programmes for Māori caregivers and their children. The early success of Tipu Ora prompted Te Puni Kōkiri to publish the *Tipu Ora Resource Kit* in 1994 to assist Māori, regional health authorities and providers who are interested in Tipu Ora as a
model for providing well child care whānau-based health services (Te Puni Kōkiri 1994c). The kaupapa of the model was to identify and address the health needs of Māori caregivers and their children from conception until the children leave kōhanga reo. The programme is delivered by kaitiaki who provide education and instruction in parenting skills and inform Māori caregivers when their tamariki need professional care. The service is delivered in the home or where ever is the most convenient place for the caregivers. The role of the kaitiaki is critical as they provide support and information to the mothers and whānau of babies in their care, and act as facilitators between mothers and whānau and the existing medical and health services.

In 2000, there were 1,980 caregivers and 2,200 children under 5 registered with Tipu Ora (Ratima 2000). In the Rotorua region there were 11 kaitiaki. During each home visit, kaitiaki are contractually required to carry out specific activities such as health education in a wide range of areas but there are other client needs that are not monitored or funded. In practice, kaitiaki undertake a broad range of activities that go beyond the programme’s contractual obligations such as transport to health and social services. Ratima described four key characteristics of the Tipu Ora approach: firstly, Māori cultural factors are emphasised in seeking to improve Māori health; secondly, the approach locates health within the wider Māori development context; thirdly, implementation of the service relies on the recruitment of a workforce that is competent in both cultural and technical terms, and has community credibility; and fourthly, the reliance upon the capacity to access Māori networks as a means to gain community support for the programme.

An important phase in the development of Tipu Ora was the establishment of their own oral health service. Mrs Inez Kingi had been a school dental nurse and it was her passion and energy that was the driving force behind the establishment of the Tipu Ora Dental Clinic. She said:
The school dental nurse was always with me; it was a part of my make up.

Her kōrero which was given for this project is crucial in understanding not only the Māori desire for good health and wellbeing, but also the Māori approach in working towards that goal.

I graduated as a School Dental Nurse in 1952. I had received the Directors Medal and graduated with honours. In those days they didn’t send you back to your home areas. The matron came to see me and asked if I would go to Te Araroa. So that was my first appointment. They hadn’t had a dental nurse up there for some time. There had always been a difficulty in getting people to go and work in isolated places. In their wisdom they thought that Māori girls would be best to work in those out of the way places. I didn’t even know where Te Araroa was!

In Te Araroa I had one little room at one end of the County Council offices which served as a waiting room and surgery. I have to say working there was the best year of my life, I just loved it! I also had to go to other outlying areas. When I went to the East Cape they brought me a horse. They would come and meet me and put all my gear, including the treadle drill, on a tractor and away we’d go, with me on the horse. I can remember the first time I went there. When I rounded the corner by the lighthouse there was this most beautiful scene; a big homestead for the farm. The homestead of the Kohere family was to be my home while treating the children of the East Cape School. I was so taken by the beauty of this place when the blimmin’ horse took off. When I arrived one of the Kohere ladies started reprimanding, “Gee you blimmin boys! You know that horse always runs away like that!”
I think they did that on purpose giving me that rough horse just to see if I would fall off. All those little incidents, they draw you closer to the people. The Kohere families there were just lovely. The grandfather Reweti Kohere, still alive then and he knew my grandfather. His wife Kate was an amazing person; we spent long hours together. I stayed there for about two years.

In 1954 I was appointed to Rotorua Primary School. Pihopa and I were engaged when I came back from Te Araroa and we were married in 1955. I resigned then and we had four children in five years. When the children came I thought I had retired from being a school dental nurse.

Mr Luke Rangi was the Principal Dental Officer. He was Pihopa’s uncle. Pihopa’s father’s sister was married to Luke Rangi so that was why we called him Uncle Luke. I was at home with my babies; two were at school and I had two at home when he called into our place to see me.

He said, “Ah, Dear, would you give me a hand at Glenholme School? There’s a lot of work to do there. Would you do it for six months? Just give me six months so that we can get things right there.”

He said he had already spoken with Pihopa’s mother, who was his sister-in-law, and she had offered to mind the children while I was working.

I said, “Yes! Yes! Yes!”

That was in 1960.

I had special privileges. I started work at nine o’clock every morning. I knew a school teacher from Glenholme School and she would pick me up in the morning and then at three o’clock in the afternoon I went home with her. I was on full salary which was good because with four children and a home to run it certainly made a difference. I worked part of my lunch hour
and managed to pick up the back log. Then Mr Rangi asked me to go to work at Sunset Intermediate. It was the first intermediate school in Rotorua. I liked it because they were older kids who were already conditioned and you didn’t have to give so much of yourself like you do with the little ones. I used local anaesthetic nearly all the time.

I remember crying when my dental nurse drilled my teeth. The first thing I did when I was appointed to the primary school dental clinic was to look for my chart. I discovered that those painful fillings were prophylactics in my lower sixes.

So I spent all my working life as a school dental nurse.

8.2 Tipu Ora Dental Service

In 1997 the Tipu Ora Charitable Trust (TOCT) was awarded a contract from the Midland RHA to provide dental care for preschool children in the designated catchment area. This was a service the funder was required to purchase on behalf of the Ministry of Health. TOCT then subcontracted to the Lakeland Health School Dental Service for the provision of the clinical expertise. Thus, a partnership was established between the Tipu Ora Charitable Trust Board and the School Dental Service of Lakeland Health. In this partnership Tipu Ora provided the Māori community base for the dental facility and the clients who were, in the main, children enrolled with the Tipu Ora programme. The Lakeland Health School Dental Service contracted to provide the school dental therapist, the clinical administration and the consumables for the clinic. The Tipu Ora Dental Clinic, situated at the Tunohopu Health Centre, Ohinemutu, Rotorua, was formally opened on the 9th of June 1997 by Mr Pihopa Kingi, the Chairman of the Tipu Ora Charitable Trust. By 2006 the contract was to provide dental care for 500 registered pre-school children and 100
children, aged from 5 to 13 years, from two local kura kaupapa (Māori schools), (Tipu Ora Charitable Trust 2006).

8.2.1 The development
The development of the Tipu Ora Dental Clinic required a considerable amount of work by the management, staff and trustees of Tipu Ora. A number of barriers had to be overcome to enable the clinic to be established. The three barriers identified were a financial barrier, a location barrier and a human resource barrier.

8.2.1.1 The financial barrier
The first and most difficult barrier to confront the Tipu Ora trustees was the funding for the initiative. This was overcome by the collective expertise that was used in the development of the proposal to the Midland RHA.

Mr Pihopa Kingi: The first barrier was the financial hurdle; getting the funding. It took us about a year to put our proposal together for the Midland Regional Health Authority.

Mrs Inez Kingi: We used all our networks. There was (the late) Ruth Nepia who worked for the Ministry of Health and she worked with you and with Te Kohu Douglas. We were in a Māori clique: Ruth in the Ministry of Health; there was Peter Douglas who worked in Social Welfare and Te Kohu Douglas. We had the support of key Māori staff. They all helped with the proposal to the Midland RHA.

Mr Pihopa Kingi: The funding for the staff was resourced under a separate contract. The contract for the delivery of the service was
between the funder (now it is the DHB) and Tipu Ora who then subcontracts to the School Dental Service. This arrangement provides for the school dental therapist and the consumables.

8.2.1.2 The location barrier

The provision of a dental service required a purpose-built dental clinic. Space was already at a premium at the Tūnohopū Health Centre, so it was necessary to determine where the clinic would be situated. It was deemed appropriate that a new clinic should be co-located along with the other existing services at the Tūnohopū Health Centre.

Mr Pihopa Kingi: For the dental service we needed to build a new wing to extend our existing building to accommodate a dental surgery. The pūtea (funding) for this came from the RHA; they funded the building and the dental clinic. The dental equipment was funded by the Nurse Cameron Trust.

Mrs Inez Kingi: The new wing was officially opened by Ross Jansen, Chairman of the Midland RHA

8.2.1.3 The human resource barrier

Māori health providers prefer to have Māori health professionals delivering their services to an essentially Māori clientele. This is not always the case and many providers employ non-Māori staff.

There was a problem getting a school dental therapist. We wanted a Māori school dental therapist but none of them would work here. I put this down to a number of things such as:
the salary component which might not have been as good;
the hours were different so there had to be some flexibility which
they may not have liked;
they did not want to work with adults; and
they had their own comfort zone and this was something new.

At the opening of the dental clinic in June 1997, the school dental therapist who was appointed to work at the Tipu Ora Dental Clinic was employed by the Lakeland Health School Dental Service. This was one of the few instances where the actual delivery of the service was not centred at a school but was based instead out in the community.

8.2.2 The implementation
Implementation was concerned with getting the service started and up and running once the funding, facilities and staff were put in place. There were a number of barriers that emerged which had to be overcome to ensure that an effective and appropriate service was being delivered. These were barriers of service promotion, access and transportation.

8.2.2.1 Promotion of the clinic
Despite the initial publicity that occurred when the dental clinic was formally opened and the subsequent work of the kaitiaki in making their clients aware of the new service, there remained an issue regarding the promotion of the clinic.

Mrs Inez Kingi: There was a requirement for the staff to build the business; that is, to go out there and promote the service and attract the clients. But this did not happen. Even going out to the people did not work; they didn’t come.
Mr Pihopa Kingi: It was not effective because the school dental therapist lacked the drive and energy to pioneer the initiative. In a school, your captive audience is there. But not for us; we were unable to do that because we weren't a school.

This was a very serious problem for the management of Tipu Ora as the concern was they would not meet their contractual obligations and were at risk of losing the contract altogether. However this problem was overcome by the introduction of an effective liaison role.

Mr Pihopa Kingi: We now have an oral health educator, an advocate, a liaison, who goes into the kōhanga reo and this is very effective.

Mrs Inez Kingi: Our liaison person was fluent in te reo Māori and was therefore able to access the kōhanga reo. This was someone from the community who knows the people; who can communicate with them, who can kōrero Māori. Then you get the children, and we did. Not only that, two kura kaupapa (primary schools) came into the clinic with their parents.

The implementation of the liaison role has proven to be very effective:

I push a lot of things in through the kaitiaki; awareness of what the service is all about. Now we get telephone calls, “When will the School Dental Therapist be there?” This is very encouraging. The question we get asked is, “When do I need to register our little one (for dental treatment)?”
8.2.2.2 Access

An initial problem that was identified soon after the clinic was opened was one of access. This problem was concerned with actually getting the clients to the marae-based service.

*I can tell you what the problems are in one word: access. For the pre-school children there must be a commitment on the part of the family to get them to the dental clinic So it is about access; it is about transport; and it is about remembering to come for their dental appointment. So it all comes back to priorities and commitment.*

Continued access to the service was an issue for some clients. When the service was first established the kaitiaki would bring many of the patients themselves whilst one kōhanga reo brought the children to the clinic by bus. However, for the particular kōhanga reo this was turned around with the service going to them:

*At the kōhanga reo, we have in two months had very high completions of dental treatment. This is because we are able to bypass the parents. We have changed the access in that we have gone to where the client is in the kōhanga reo itself rather than have the parents bring the children here to us at the clinic.*

Another critical strategy that was implemented by the provider was the use of an interpreter at the kōhanga reo:

*Our school dental therapist was able to treat a group of children that other school dental therapists had not been able to access. These were children who were seen as a pretty wild bunch of kids. These were children who*
were seen as 'those Māori kids out there'. These were seen as kids with a language barrier. That is, they were at kōhanga reo where te reo Māori was the norm; if you are not able to kōrero Māori then you were not able to engage with them. So we overcame that quite easily. We had an interpreter. All the children at that kōhanga reo saw our school dental therapist and were treated by her as we had our interpreter present. Some of these children required four or five appointments to complete their treatment plans and we did just that. Other mainstream providers had failed, and had freely admitted that they had failed to treat these particular children. Although this was an extreme case for the School Dental Service, their dental therapists would not go there. They would not go to this particular school.

This was an interesting scenario which was able to be remedied by a Māori provider for and on behalf of the School Dental Service. It clearly demonstrates the advantages of Māori dental health services and the value of having a diversity of oral health services. One strategy to ensure continued access to the school was to have appropriate and effective dialogue between the provider and the school:

There was one basic thing: Listen to what the client school wanted. Therefore to break down the barrier, we moved to provide the service in the way that they wanted the service provided. They wanted the service delivered in te reo Māori. As a result schools and kōhanga reo have allowed us access. We have taken on other schools.

8.2.2.3 Transport

It has been widely recognised that a barrier to accessing a health service for many disadvantaged Māori was transport to the service. In an interview some two months
after the service had been underway, the original dental therapist said (Te Ao Mārama 1997):

One of the main differences in this service, compared to where I was working before, was that if transport is a problem for the children and their parents, then we are able to cover that and bring them in.

An issue concerning the transport to the clinic was the cost of that transport. This concern had been identified as a major issue for the Māori provider:

*The contract arrangement with the DHB does not allow you to do some things. The school dental therapist can barely make it around all schools, let alone the kōhanga reo. We can’t do the kōhanga reo because there are boundaries. They will come to us in a bus, but that stifles the service because there is no funding for transport.*

*We can’t get the children down here because of transport; we are not funded for that.*

However, a lack of funding for transportation was not, in the end, going to be a barrier to the service:

*The kaitiaki have formed a relationship (with the whānau) and go and collect the child.*

There was a determination that the children should not be denied access to the service because of a lack of funding for transport. The *kōhanga reo* were prepared to bring the children to the clinic at Ōhinemutu:
But the people are prepared to just do it.

This is a very compelling statement. Both the provider and the client group were adamant that a lack of transport to the clinic would not be a barrier.

8.2.3 The operation

In the establishment of a new service, teething problems and the unexpected are issues that have to be dealt with on a day-to-day basis. There were a number of issues that arose during the first two years of the service being introduced which had to be addressed to ensure continuation of the service, continuation of funding, and credibility with the client group. These were issues that were to do with the provider on one hand, (staffing, adequacy of funding, contractual obligations) and on the other, there were issues that were to do with the client (dental awareness, dental perceptions, cooperation).

8.2.3.1 Staffing

Maintaining ‘good staff’ is a widespread concern for any provider as staff can move on to other employment opportunities for a whole variety of reasons. The Tipu Ora Dental Service was no exception.

We had difficulties with staffing for a while. After our first school dental therapist had left we had part-timers for three months and then for six months. This was no good to us as we had occasion when we had a child who needed attention and we did not have a therapist. You also need to have continuity of care. People want to know that they can come in at any time and be seen.
The current dental therapist had made a significant impact with not only the client group but also with the provider itself:

*Now although our school dental therapist is non-Māori she has that X-factor, or M-factor if you like. Her hūmārie (a quality of gentle quietness), her āhua (demeanour) her way, her style, her empathy is beautiful. She has a very gentle way about her.*

*As a Pākehā working in that field, it is not rocket science to know how you treat people; it’s just about good manners. Wairua and aroha.*

The therapist commented (Farr *et al.* 2003):

*It is about Māori helping Māori in a cultural and holistic way and just going out to meet the needs of the people in a truly manaakitanga (supportive) manner.*

### 8.2.3.2 Adequate funding

The provider recognised that it took a certain amount of time to develop a good relationship with their patients. When the fiscal constraint of ‘time is money’ was applied to the delivery of service, a conflict arose:

*With our preschool children it takes two appointments. On the first appointment it is just a case of getting to know the child. That approach is so much better before anything nasty has to happen. The key thing is gentleness. But the problem is that this takes time, and time is money. This is not seen in the funding arrangement with the funder.*
However, the Māori response to this situation is the whakatauākī (proverbial saying) *He aha te mea nui o te ao? Māku e kī ake; he tangata, he tangata, he tangata.* (What is the most important thing in the world? I will say it is people, it is people it is people). Although the funding for the service covered the salary and expenses for the dental therapist, there was no funding for an administrator or chair side assistant. It soon became evident in hindsight that had such positions been funded then the service would have been more efficient. For example, with cancelled or missed appointments the administrator would have the time to ensure that the daily appointments were fully booked and the contractual outputs met.

### 8.2.3.3 Contractual obligations

There were initial concerns on the part of the provider over the first two years of the new service that they were not meeting their contractual obligations with regard to the number of clients who were seen and treated. This was attributed in the main, to a totally new service being instituted and the time it took for “the word to get around.” That it took some time for the service to become firmly established and accepted within the local community was unexpected. However, after four years there was a clear acceptance and support for the service:

*The Principal Dental Officer conducted a clinical audit. No children were found to be wanting. It was very good. It was a huge success for the individual practitioner and for the service. Our figures are way above the average with regard to outputs and completions.*

That the Tipu Ora Dental Service was able to meet its contractual obligations with regard to the number of patients seen was due to the manager of Tipu Ora taking a
proactive role in ensuring that the service was promoted throughout the region and providing a liaison role with the community, kōhanga reo and kura kaupapa.

A further problem arose with the resignation of the dental therapist who moved away from the area. There were some difficulties in finding a replacement which resulted in periods of time without a clinician and a resultant loss in continuity of service.

8.2.3.4 Dental awareness

Tipu Ora had been concerned about an apparent lack of knowledge about dental health on the part of some clients. This was a challenge for the first dental therapist employed by the provider who stated in a newsletter article (Te Ao Mārama 1997b):

In the time that we have been going, I have 80 enrolled tamariki and there has been a clear pattern of needs identified so far. Generally speaking, the oral health of the one-year to two-and-a-half-year old children is good, but in the four to five-year age group, there is a lot of work to be done: 15 children needed extensive work. Of these, I have had to refer 3 children to the hospital for a general anaesthetic for their dental care, both extractions and restorative work. It's that old “Bottle Caries” which is still a problem resulting in the anterior teeth being decayed to gum level. However, the parents are generally very receptive, and making them more dentally aware is an important part of the job.

The need to continually promote oral health and “sell the messages” of healthy behavioural practices, diet and oral hygiene was recognised very early by the provider:

There is a lack of awareness about dental health on the part of many parents. The fact that what I do now does have implications for the future. So what is the likely impact of that? What is the likely impact of what I do now, in
say, 2-years time? The parents don’t associate the sweetness in the mouth now, with what will happen in later life; the development of tooth decay.

Increasing awareness is an ongoing challenge for the provider. Parents are encouraged to attend with their children and considerable dental health information pamphlets and resources are available.

8.2.3.5 Dental perceptions

A universal response to dental treatment is the fear of pain.

The perception is that everything to do with dentistry is pain.

In order to overcome the stereotypical perceptions of dentistry, and in particular, the New Zealand concept of the ‘Murder House’ the provider has instituted a number of critical strategies:

We ensure that we make coming to the dental clinic a good experience. We have a toy box.

The style and manner in which the service was delivered had come under scrutiny by the provider and positive changes were implemented:

We have changed things considerably to make the service so much more appropriate right down to the clothes the school dental nurse wears. So she may not wear the traditional white uniform. She wears a fairy costume. The kids love it!
She has gone right down to the kids’ level and done it without the parents being present. This is because sometimes the parents bring their own unfavourable experiences. We go all out to ensure that our experiences with the tamariki are good experiences.

Other school dental therapists here think our service is a good thing; there is no negative feedback.

8.2.3.6 Cooperation

A problem with any dental service is non-cooperation on the part of some patients. Non-enrolment and non-attendance are frustrating for the provider. The Tipu Ora Dental Clinic was no exception. This was overcome by providing an added incentive to attend:

We have a draw every month for a $50 voucher. Every child that has been to the clinic that month goes into the draw. For some whānau a $50 voucher is a huge thing.

An important responsibility recognised by the provider was to ensure that cooperation and attendance was as high as possible:

It all comes down to ourselves. We do a huge amount of time and effort in chasing up non-attenders. The reasons for non-attendance is that families move or they just can’t be bothered. If the patient never turns up, we follow up. Sometimes they still don’t turn up. How many times do we have to follow up? As much as it takes. Many families are transitional; they move in and out of Rotorua; over to the coast; back and forth; and move to where ever the work is. As a result children fall between the cracks and miss out.
The provider also noted that on occasions there was an issue of non-compliance by parents who failed to sign the consent forms for dental treatment. This was always followed up by the *kaitiaki* who ensured that the documentation for enrolment was completed. This highlights the important role of the *kaitiaki* in the team approach for Māori health service provision. If these tasks were to be done by the therapist alone, then it impacts negatively on clinical time with a reduction in clinical outputs.

8.3 Provider Relationship With The Funder

The provider saw their relationship with the funder as being very important even though the submission of proposals for dental services and applications for funding and contracts was fraught with frustrations:

*It is very difficult to plough a rocky road. Negotiating contracts is not a pleasant experience. To begin with there is the definition of the service that needs to be delivered. Our service is different from what has been traditionally done. Although we have a school dental therapist we are not a school.*

*We made an application to the DHB for funding for inequalities funding to extend our service but it was unsuccessful.*

Although the provider had recognised and experienced difficulties with applications to the funder, this was not a reason to give up. This only served to harden the resolve of the provider to continue to seek and deliver the best possible services for their client base:

*There are plenty of boulders out there.*

*What we have to do is to find a way to walk around them.*
The maintenance of a good relationship between the provider and the funder, despite the difficulties, resulted in a positive outcome with an expansion of the services being provided to some primary school children as well:

*In our contract with the DHB, Tipu Ora has overstepped the mark. We were only contracted to treat the pre-school children, but we can now provide treatment with certain named schools.*

A common complaint from Māori providers is that the funder’s perception of how they deliver their service is often not the same as how the provider see themselves and how they deliver their service. There is a perceived mis-match between the funders’ service specifications and the Māori providers’ service delivery. This perception is very real and was articulated to the Māori Health Commission (1998b):

> We have outcomes and outputs that don’t fit the models that have been imposed upon us. We are struggling to survive because we can’t produce the ticks in the box. The means of evaluation in the Pākehā system are not appropriate for us.

These sentiments were also expressed by the provider:

*The disadvantage is that they want to put us into this square box here, and then present us with all these other boxes that we are expected to tick off under our contract. But what we do as a Māori organization, the way we do things as a Māori organization, that doesn’t work for us. For example, the kōhanga reo that wanted us to come and provide dental care for their tamariki, but we couldn’t because they are outside our boundaries. That particular kōhanga reo was regarded as being very difficult; no other provider was able to get into that school. But we did. We listened to them*
and it was just one thing that they wanted. They wanted people who would kōrero Māori; that’s all it was. So we did that. We arranged for our people to go in and kōrero Māori. We had a popular entertainer who went in with the health messages all in te reo Māori and then we went in behind that. It worked and now we are successful in that school.

8.4 Dental Student Clinical Attachment With The Tipu Ora Dental Service

A new relationship was established in 2000 between the Tipu Ora Charitable Trust Board and the University of Otago Dental School in which a small group of final year dental students spent a week at Ōhinemutu providing basic dental care for the whānau of the Tipu Ora children. This originally occurred at a time when the dental programme was in a state of flux with a less than satisfactory number of clients accessing the existing dental service. To provide support for Tipu Ora and to help promote the dental clinic, a plan was devised to provide free dental care for adults at the same time giving the opportunity for dental students to gain valuable experience working with a Māori community based oral health programme. The dental care was provided by final year dental students using the clinic at the Tūnohopū Health Centre augmented by a mobile unit on loan from the Lakeland Health School Dental Service. This plan required the co-operation of a number of entities to make the plan work: firstly, co-operation of the School Dental Service for the loan of the mobile dental surgery; secondly, the co-operation of a local dental practitioner for clinical back-up and support; thirdly, the co-operation of a local pharmacist for any required medication and prophylactic antibiotics; and fourthly, the co-operation of the University of Otago Dental School for their support. Needless to say, the co-operation was forthcoming and was attributed to the reputation and relationships of Tipu Ora. Comments from the students’ evaluation highlight the value of such a programme for both the students and whānau (Broughton 2000d):
Working in a dental environment was good for my studies, but working with my people was good for my wairua. I want to go back!!

The experience - it was fantastic to work with the Te Arawa people. It was so nice to walk away at the end of the day and know that you had treated many patients that would never have gone to the dentist normally, and saved them hundreds of dollars.

I gain both valuable clinical experience - independent clinical judgment and treatment but I also gained a lot in other areas. The experience of the marae and its way of life was extremely valuable and opened my eyes to many aspects of Māori culture I had not experienced before.

This was the best week I've had at Dental School.

This programme has now become a well established part of the Tipu Ora annual calendar.

8.5 Te Kōrero (The Discussion)

In the development, implementation and operation of the Tipu Ora Dental Service there were two clear factors which were responsible for its success and consequent continuation of funding. These were: firstly, the relationships that the provider has created and maintained with the stakeholders; and secondly, the passion of the people who work with and for the provider.

8.5.1 The relationships

These are the relationships that the provider has with the funder and with the clients. The latter include the patients and their whānau, and the schools. Whilst there had been some tensions between the provider and the funder in the initial years of the
service being established through a slow enrolment and under-utilisation of the service that situation has completely changed:

There has been a very big change. I put it down to the personality of the therapist.

The commitment, chair-side manner and uniqueness of the clinician was obviously critical in gaining and maintaining the confidence and respect of the community of clients. This occurred with the support, work and collegial relationships with the kaitiaki, management, staff and trustees of Tipu Ora. The excellent relationship between the clinician and the patients elicited a very compelling statement from a member of the Tipu Ora management:

It’s just great when you hear our people saying,

“I must come in for my dental check-up.”

The positive outcomes from the service provided by Tipu Ora was recognised by the funder:

The School Dental Service is particularly proud of the situation that we have now.

8.5.2 The passion
This value is critical and is exemplified in the proverb, “if there is a will there is a way.” The trustees, management, staff and clinicians are totally committed to ensuring that the best possible dental service is available and accessible to their local Māori community:

When I arrive at work I see all these tamariki coming into the clinic. We’ve got the best dental nurse you could ever possibly want. The kids are
coming in. The schools are with us, the kōhanga reo and the kura kaupapa. The parents are there too. Our dental therapist wants the parents to come; it’s that little touch that she has. It gives the tamariki so much more confidence and the atmosphere suits the parents. When the kura kaupapa children come, the parents are always with them.

Yesterday two darling children jumped out of their car and ran into the clinic. I said, “Kia ora” to them and they were just so happy to be there.

8.5.3 The future of the Tipu Ora Dental Service

The future development of the Tipu Ora Dental Service has been under discussion by the trustees and management of Tipu Ora:

Our current kaupapa is that we have a service that caters for pre-school children; if that could be extended to treat adolescents as well would be excellent.

What we want is our own mobile service. Just like when the circus comes to town; here comes the caravan. This way we could access the high school children as well. In high schools there are health services with GP doctors and nurses. It would be good to have a dental service along side them.

As for an adult service, well where to from here? We have looked at Chris Taylor’s service in New Plymouth. We would need to look at our building capacity and how we would incorporate another dental clinic. It is not impossible.

In March 2006 the Tipu Ora Charitable Trust put forward a proposal to the Lakes District Health Board and Health Rotorua Primary Health organization for funding an expanded dental service consisting of a dentist, chair side assistant, dental receptionist
and dental co-ordinator. Whilst the funders acknowledged the importance and need for such a service, there was no funding available in the financially stretched Health Board1.

This failure to attract further funding to provide services for adolescents and adults has not detracted from the determination of the staff of Tipu Ora to continue to provide the best possible health service they can for their current client group, the Tipu Ora children, despite the problems that emerge along the way. The partnership between the Māori Health provider, Tipu Ora and the Lakeland Health School Dental Service is a unique situation which has resulted in the dental health needs of a predominantly Māori pre-school population being met in a manner which is acceptable and appropriate for them. The overall success of the dental service has enabled Tipu Ora to extend their services to some kōhanga reo, kura kaupapa and primary schools. Their ultimate aim is to provide a seamless oranga niho service for all age groups. As one Tipu Ora staff member said:

_It will happen eventually, perhaps not today, perhaps not tomorrow, but it will happen. Watch this space._

1 Personal communication, Ms M Rolleston, Administrator for Tipu Ora.
Chapter 9

The iwi-based model: Te Ātiawa Dental Service

9.1 Ngā Timatanga (The Beginnings)

Te Ātiawa is one of eight generally recognised iwi of Taranaki. The iwi has approximately 13,000 members. Te Ātiawa iwi is located in the vicinity of New Plymouth (Te Ātiawa 1999).

Dr Tony Ruakere is a Māori GP who has been in practice in New Plymouth for over 30 years (Royal New Zealand College of General Practitioners [RNZCGP] 2003) and during this time became very concerned about the health of Māori people in his community. He observed that many Māori were not accessing primary health care or their late presentation increased the severity of their sickness. These factors highlighted the poor health status of some Māori within his local community¹. To address this very serious concern he established a Māori medical practice under the auspices of the local Te Ātiawa iwi through the formation of Te Ātiawa Rūnanga Medical Trust (Ruakere 1998). He stated (Māori Health Commission 1998):

We just went out and did it and then we talked about it afterwards. I was in GP practice in the mainstream situation, but I could see that for some reason Māori were not accessing the GP service. So I sold the GP practice and set up on the marae. We just went ahead and set up the Te Ātiawa Medical Centre. Now we have two clinics providing the whole range of GP services for whānau. And it is working. Mind you it wasn't an easy process but we were determined that the right sort of medical practice was available for our people. When we started out we had no funding, no contracts, no equipment and no fees. Now we have probably the busiest GP practice in town. As I said, we just went out and did it and talked about it afterwards.

¹ Dr Tony Ruakere, personal communication to the Maori Health Commission, 1997.
This was an example of *tino rangatiratanga*, an assertion of Article II of the Treaty of Waitangi which guaranteed the right for *iwi* to exercise authority over their own affairs. In this case, a problem had been identified and an intervention strategy developed and implemented to address it. The new Māori-focussed medical centre grew rapidly (Ruakere 1998):

We were astonished when the first one thousand patients had registered in the first three weeks – this has since grown to three thousand patients.

Dr Ruakere found some very marked differences when he compared the new *iwi*-based medical practice with his previous mainstream practice. With 3,000 patients in each practice there was a very different ethnic make-up; whereas in the mainstream practice there had been 2,600 non-Māori and 400 Māori patients, there were 400 non-Māori and 2,600 Māori patients in the new *iwi*-based practice. Another marked difference between the two practices was the prescription items: 128 per week in mainstream (the weekly average for New Plymouth at that time was 120 items per week) compared with 550 in the *iwi*-based practice. This was a clear indication of the extent of illness and pathology in the *iwi*-based practice. The high rate of pathology was remarked upon by an Examiner for the Royal New Zealand College of General Practice who stated (Ruakere 1998):

I have never seen so many major system diseases in one surgery session anywhere else in New Zealand. (Diabetes, emphysema, asthma, hypertension, coronary artery disease, drug addiction, auto immune disease, heart failure...)

A second practice was opened in Waitara with two thousand patients, 80% of whom were Māori. Two barriers to accessing medical care were the doctor’s fee and the prescription fee. To overcome these barriers, both fees were abolished for community card holders. In 2003, Te Ātiawa Medical Centre continued to maintain the two surgeries in New Plymouth and Waitara, and became a member of the Tihi o Hauora o Taranaki Primary Health Organization
There were 2.5 FTE male doctors, 3 practice nurses and 2 receptionists.

Another pathology indicator that presented in the patients at Te Ātiawa Medical Centre was dental disease. Dr Ruakere remarked (Broughton 2000):

The state of the teeth in the patients who attend our medical centre is appalling. Toothaches, broken teeth, oral infections, gum disease, we have the lot. Dental disease is right up there, and there is very little I can do about it.

Dr Ruakere² reported that it was cheaper for patients to present themselves at his medical practice for analgesics for a toothache than it was to go to a dentist. A New Plymouth dentist commented:

*Dr Ruakere was referring patients to the Dental Centre at Taranaki Base Hospital. That was fine because they could take care of the acute dental problems.*

As a result of the high prevalence of dental disease (toothache, edentulous spaces, periodontal disease manifested by bad breath in particular, and obvious caries) that presented at his medical practice, Dr Ruakere saw the need for a dental service as an integral part of Te Ātiawa Medical Centre. A New Plymouth dentist noted:

What happened was that the patients came to see the Dental Centre at the hospital as "their dentist." They kept going back there for ongoing treatment. They were told, "Go away. We just looked after your immediate problem; fixed up that toothache or whatever, BUT we don’t do anything more."

² Personal communication, Dr T. Ruakere, Te Ātiawa Medical Centre, New Plymouth, 21 November 2003.
Foster-Page, in a study of adolescent oral health, found that some Taranaki children are missing out on adequate dental and orthodontic care (Foster-Page 2004). The survey involved 430 twelve and thirteen year-old children from four intermediate schools in Taranaki. The key finding was that both dental caries prevalence and severity were greater in Māori and children from low socio-economic status environments or low-income areas. This study was important in the drive to improve oral health for the whole of Taranaki and to address issues of a lack of access to (or the ability to afford) appropriate dental and orthodontic care.

Emergency dental care for low-income people only provides for relief of pain and control of infection. Funding is available from Work and Income New Zealand (WINZ) up to a maximum of $300 per year for each eligible person. To address the unmet dental needs of the local Māori community, to provide an accessible service for Māori adolescents, and to provide the best possible treatment outcomes, a more comprehensive service was required that was both affordable and non-threatening.

9.2 Te Ātiawa Dental Service

9.2.1 The development

Like the Tipu Ora Dental Service in Rotorua, a considerable amount of time, energy and discussion occurred in the development of a plan to establish an iwi-based dental service as part of Te Ātiawa Medical Centre. Once the concept had been formalised, turning it into reality and making it happen was fraught with difficulties. What was required were human resources, a dental surgery, and funding for running costs. On the surface these would appear to be insurmountable barriers. However, one way or another, they were overcome and a new service was established. The new Te Ātiawa dentist stated:
There are two things that are important in the whole operation; two things, people and dollars. The first thing, it's about people; having the right people. That's just so important. The second thing is having the money to pay them to do the job.

9.2.1.1 The human resource

The first and critical factor, if Dr Ruakere was going to be able to respond to the dental needs of his patients, was to have a dental surgeon who would support and drive the development of a new service. This was achieved through the enthusiasm of Dr Chris Taylor, a New Plymouth dentist who had been in practice for many years who stated:

Why did I decide to start up a Māori oral health service? I went to the first Oranga Niho National Hui where Te Ao Mārama was established. That would have been back in 1996. Halfway through the hui I decided what I was going to do; that was to set up a dental clinic for Māori people. I came back to New Plymouth and saw Dr Tony Ruakere. He had set up Te Ātiawa Medical Centre. He had found that dental problems were very common among his patients and that there were all sorts of barriers for them to seek and receive dental treatment. He wanted someone to take care of all the acute stuff. But I said, “No, we need to do more than that.”

Emergency dental care under the publicly funded scheme for low-income people provides basic treatment for an acute dental problem. Any long-term dental care for the patient and ongoing definitive treatment is not considered. There was now a willingness to provide that care by a potential Māori provider. Te Ātiawa dentist commented:

The patients need care, overall care, not just fixing their teeth. So it's about changing attitudes, bad attitudes that don't in the end do anything long term for the patient. If the patient goes mainstream, then it's more often than not, rip shit
and bust. Working in mainstream you are working against the clock. So many patients have to be seen in so big or so small a time slot. They just treat the dental problem with little or no attention to the overall patient. Like a factory, in one end and out the other minus a few teeth. I suppose that sounds a bit tough, but that’s the way I see it. But that way, doing things like that, is just not on for us. That approach can’t be part of a health service for Māori. When we talk about the overall care of the patients, that’s exactly what we mean. That is why such a service as ours is so important. We can provide that ongoing care.

Dr Taylor is Ngāti Kahungunu Ki Wairoa. Although he does not whakapapa to any of the Taranaki iwi he felt that this was not necessarily a disadvantage:

Then there is the politics as well. Tui Ora3 and the whole field of providers. There are the local iwi and hapū and there are the local providers who may not be iwi-based, if you get me. It was important to be aware of all of that. It could have been a barrier in setting up. Having come from outside the area, I believe has made it a whole lot easier. I can walk right across the barriers.

Dr Chris Taylor was therefore the key person in the development of Te Ātiawa Dental Service. Without the dedication of such a person, there would have been little likelihood of any such development.

9.2.1.2 A dental surgery

The establishment of any dental service requires considerable capital outlay for the purchase and installation of dental equipment, plant and stock. Initially there was no capital funding

3 An integrated health service organization for Māori providers
available from the RHA, Te Ātiawa iwi or Te Ātiawa Medical Centre. That a dental surgery was able to be set up in the first place was due solely to the goodwill and commitment of those involved:

When we set up we received no funding from the RHA or subsequently the HFA. I re-equipped my own surgery and brought the old equipment here to Te Ātiawa Medical Centre. It was more than adequate. Te Ātiawa provided the space, the power and electricity. I purchased new instruments. We had an extended credit from GUNZ (a dental supply house) which was pretty handy at the time. Eventually we were able to be refunded for the instrumentation. GUNZ now provides us with our supplies at very good prices; at Government issue prices which is a huge help. Dentsply gave us the x-ray developer.

Another important aspect in the development of the new dental clinic was having an adequate physical space which could be appropriately adapted:

The crucial thing is to have the right sterilisation. As long as you have enough instruments, all you need is the basic stuff and a sturdy unit. A good sterilisation system is what you need. Then you can be very confident about all the right protocols and cross-infection stuff and doing the right things efficiently. Ideally you need a separate room for the sterilisation. Here we just have the one room, the clinic for the patients and the sterilisation. You need the ability to turn the instruments around quickly, a six-minute turn around time. Okay, so they may be a bit hot, but they are sterile and that’s what matters.

However, there comes a point where old and outdated dental equipment must be replaced in order to maintain an efficient service and the safety of both clinicians and patients. Funding was sought to re-equip the dental surgery:
Funding became available through the Māori Provider Development Scheme. We received a grant of $2,000 to develop a proposal for full funding.

Attempts were made to gather support for the proposal from the Members of Parliament. Once this was eventually obtained, a full proposal was submitted to the Midland HFA:

We sought the support of the Māori members of Parliament in the first instance but did not receive any response from them. So our local MP for New Plymouth, Mr Harry Duynhoven, was very helpful. He was able to provide a letter of introduction from Mrs Tariana Turia, MP from Wanganui to the Midlands HFA. Within the Midland HFA it was Ruth Rhodes and Karena Elkington who we hassled and was able to follow through for us. As a result we were able to purchase a whole new surgery for $58,500.

9.2.1.3 Funding

The third barrier to overcome was on-going funding. How was the dental service going to pay its way? The patient group were low-income people with little or no financial resources of their own to pay for dental care. It was anticipated that no fees would come from the patients.

Funding was provided by Work and Income New Zealand for beneficiaries for some limited dental treatment, and a Taranaki District Health Board contract for emergency dental services for community cardholders was negotiated:

I have a contract for emergency care for Community Card holders. The contract is worth about $3,000 per month. We are able to do the bulk of the work under this emergency care. This is an essential part of the cash flow of the service. If the patients are on a benefit, then WINZ provide the payment for dental treatment.
We have a very good relationship with WINZ. At first we had to see the patient, make a quote for the work to be done, and then the patient had to take that down to WINZ to get an approval. Now we just do the work first and bill WINZ later. It works really well. What we try to do is to get as much work done that we can do within the $300 payment from WINZ.

Whilst this arrangement worked for the benefit of the patient, there was the need to provide adequate financial support for the clinical staff. The extent of the dental disease in some patients made it difficult if not impossible, to provide total oral rehabilitation under the funding available from WINZ.

We are up against it. Clearly within our surgery we see the whole area of dental neglect. We see people who haven’t been for 10 or 15 years or more! The last person they saw was a dental nurse at primary school and now they might be an adult of 30 or more years old. If we haven’t got the right people seeing them, understanding them and their ways, the way they talk, what they say and all of that, then it’s a case of the same old thing. The patients just get the bottom line, extractions. So the right people are essential, and as I said, having the money to be able pay them a decent salary.

The need for a team approach with a dental therapist working in conjunction with the dentist was seen as being an efficient use of clinical expertise:

A dental therapist can also act as a dental hygienist. So having a person like that with a chair side assistant can be very effective. Now we can train up a chair side assistant. We can do that for something like $1,000 per month. When they are in position I can start to delegate the work and then I can be utilised so much better. So on the money side of things, a Māori oral health service needs sufficient
funding to pay not only the dental therapist come hygienist, but the dentist as well.

Sufficient funding is needed to pay them all a decent salary to keep them all happy.

Te Ātiawa Dental Service was established in response to an identified need for an iwi-based dental health service in New Plymouth. Te Ātiawa Dental Service opened on 22 March 1999 with the aim of providing much needed dental care to a predominantly Māori client base (Te Ao Mārama 1999). The clinic operated for two days a week with the aim of providing a full range of dental services for whānau. Although WINZ funding was available for low-income people, and a contract with Taranaki Healthcare to provide emergency services had been negotiated, the maintenance of a dental service on that basis puts the long term viability at some considerable risk.

9.2.2 The implementation

As was the case with the Tipu Ora Dental Service, implementation is concerned with getting the service started and running once the staff, funding arrangements and facilities are put in place. The two barriers identified during the implementation stage were firstly, the establishment of a profile within the local community, and secondly an administration concern.

9.2.2.1 Service profile

Like any new business or service, the potential clients need to know that they are there and what they do. Te Ātiawa Dental Service was no different in this respect, even though it was part of an existing Māori primary health care service.

In our operation you need the foot-traffic. You need the profile. Now we are at the stage where everybody knows. That is, everybody knows us, Te Ātiawa

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Dental. That’s good because then we know we are part of the local scene. They accept us for what we are and what we try to do.

The profile and marketing of any new venture is naturally a matter of concern, but as it eventuated, there was little need to worry in this instance. Dr Ruakere commented:

*He’s so busy that if we had a full time dentist, he still couldn’t keep up with all the work.*

The Māori community networks ensured that the service became widely known. A successful strategy to profile the service was the organization and participation in *oranga niho* promotion activities:

> We have been involved in *oranga niho* promotion days and activities, mainly with the schools. We have a contract from Tui Ora to deliver oral health promotion to schools. We have been doing it for about 5 years now. *Oranga niho* promotion days are a good way of getting the profile of the clinic out there with the people. *And like I said, they know us.*

> It’s time now however, to let that *oranga niho* promotion contract go. The administration of the funding got too much so I decided to hand it on. Tui Ora will now employ an *oranga niho* educator and that’s great.

9.2.2.2 Administration

The administration of any health service is a vital part of its organization and function. The reception and responsiveness to the needs of patients entering the service requires careful management.
Sharing a receptionist with the medical service does not work all that well. The medical receptionists do not understand the dental needs of the patients when they telephone. They often say that we are booked right up until the end of January. Now that is three months away. They don’t seem to appreciate that they need to ask things about their toothache, how long it has been troubling them; have they had to take any pain killers and so forth. Then a reasonable estimate can be made of the time it may be required for an appointment. This makes the running of the dental surgery so important so that we don’t get a whole lot of patients coming in at about the same time. There needs to be two receptionists; one to look after the doctors at the Medical Centre and one to look after the dentist. The receptionists are not always empathetic with the dental patients when they arrive at the surgery, so that can be a barrier right from the start.

Whilst reception procedures may not always be ideal, they are managed as well as possible given the limited resources.

9.2.3 The Operation

There were a number of issues that arose during the first months of the service being introduced which needed to be addressed to ensure the provision of an effective, efficient and acceptable dental service. These were issues that were to do with the client (co-operation, severity of dental disease and te taha hinengaro).

9.2.3.1 Co-operation

After the service was underway, it became clear that missed and failed appointments occurred almost always in the mid and late afternoon:

When we started off we did a whole day at the clinic. But we found that the afternoons were full of failed patients. They just didn’t come after 2 pm. They
wanted to be at home then; I suppose they wanted to be home when the kids came home from school. So now we have two morning clinics, one on Tuesday mornings and the other on Friday mornings and that works really well.

Changing the hours of the dental surgery to suit the patients was an easy matter to reconcile.

There was also a continuing problem with failed appointments with Dental Benefit patients. An innovative incentive was put in place to overcome this problem which has worked very well:

For our Dental Benefit patients we have a $50 draw each month for a voucher.
This improved the appointment compliance no end.

9.2.3.2 The severity of the dental disease

The severity of the dental disease which presents at a dental surgery can often be a very difficult and time consuming aspect of clinical work that requires very careful management.

Dealing with children has also had its problems. Case in point: a very young Māori girl who had dental problems, terrible pain and toothache. The mother brought her in and when I saw her it was obvious she required a general anaesthetic in order to treat her. But there was 6-month waiting list before it could be done. The mother came back to me in desperation and said we have to do something. I thought of giving her some sedation to slow her down a bit. The mother talked her through it before she came in, to prepare her. We did it but it was awful because we had to hold her down; the poor wee girl screamed and cried and everything. I felt pretty terrible myself. But at the end, well what a difference. She smiled at me and I knew we were okay. I gave her a hug and she was pretty good. Her mother picked her up and hugged her and as they left the clinic she
looked over her shoulder at me and smiled again. I’ll never forget that. I thought, “Yes! We are there for them - whānau,” and that’s what it’s all about really.

The trouble was a few weeks later we had to go through the whole thing again.

9.2.3.3 Te taha hinengaro

Having to manage te taha hinengaro, the mental and emotional state of a dental patient, can be very demanding for a dentist. Te Ātiawa Dental Service has had a number of patients that required careful and compassionate management. Two clinical cases were presented to illustrate the depth of empathy, understanding and awhi (caring approach) that was required for patient management in order to successfully complete a course of treatment.

Case 1

Case in point. Sexual abuse. Yes I’m sad to say we do see a number of patients who have been sexually abused. It’s got to the point that we can tell. We know that something has gone on because we can recognise things, the signs. One of the signs is that they pull up their legs. What I mean is the patients sit in the chair and pull their knees up, sometimes to their chest. Then when we try to start the oral examination, they pull away. When we go into the mouth they pull their head away. Like, because, that is where they may have been physically hit. The thing about it is time, and taking the time in talking them through it. That’s why it is so important to have an older person, a woman who can talk to them. That’s what I am able to do and I have found that they are able to talk to me and then they get to the stage where they are comfortable with accepting the dental treatment. The thing is finding the time to do that, to quietly talk with them. That’s why I say that in mainstream, there just isn’t the time to do that.
Case 2

Case in point. We had a patient that had been sexually abused by a dentist. She described the dentist as being over the top of her; right over on top of her in the dental chair and doing whatever he did. Well now, she was very fearful of dentistry. So we had to overcome that. She had to realise that we were not a threat. That took six months of fairly regular appointments. In the end we were able to undertake some successful root canal therapy. So doing all of that took an awful lot of time. If we were tied down with a fee for service, then we could not have done that for her. It was a matter of having the time, by making the time. Without the time, you can't really meet their treatment needs. The key is finding that time.

Overcoming these clinical difficulties and producing successful dental treatment outcomes for the patient required two things in particular; firstly, an older woman who gained the trust and confidence of the patient; and secondly, making appropriate time available. These treatment needs were met through the chair side assistant who was the dentist's wife taking the role of whaea (respected woman elder/mother role) who ensured that ample time was available to kōrero (talk through and discuss issues) with the patient. That Te Ātiawa Dental Service was able to manage these successfully highlights their commitment to their patients and to the kaupapa (philosophy).

_The clinic functions very well given the limited resources._

9.3 Te Kōrero (The Discussion)

In the development, implementation and operation of Te Ātiawa Dental Service, just as it was for the Tipu Ora Dental service, there were two clear factors which were responsible for its
success in ensuring that the service was established in the first place. These were: firstly, the relationships that the provider has created and maintained with the stakeholders; and secondly, the passion of the people who work with and for the provider.

9.3.1 The relationships

The maintenance of good working relationships within the health sector and with the Māori community is an essential component of any Māori health service.

_We have a good relationship with the other Māori providers. Tui Ora is the collective of Māori providers. There are a lot of them. Taylor Dental Practice is affiliated to Tui Ora. There are 29 providers under that umbrella._

However, maintaining those relationships can pose its own difficulties:

_I haven’t been able to utilise the networks as much as I’d like. It’s just the time required to do all of that. I mean, you can imagine what it is like; there are a lot of people involved over the entire Māori health area here._

On 11 December 2003, Dr Taylor made a presentation to the Taranaki District Health Board (TDHB) concerning “oral health services in Taranaki and particularly with respect to the service provided by Te Ātiawa Dental Service” (TDHB 2003).

Dr Taylor informed the Board that the current oral health services were not meeting the needs of the community, particularly in the 20-year plus age group with access being the main problem....Funding was provided by Work and Income New Zealand grants and a Taranaki DHB contract for emergency dental services for community card holders. 80 per cent are Māori but the service is becoming the first point of contact for many community service cardholders. However, due to the funding constraints, the service cannot meet the demand.
Dr Taylor put forward the following suggestions to the Taranaki DHB for their role in providing oral health services to the region:

- Taranaki DHB to take a lead role
- Dare to be different
- Regional problems require regional solutions
- Te Ātiawa Dental Service had found a way forward but needed support from the Taranaki DHB to build the infrastructure that would enable the service to provide for the community
- Currently developing a service under Te Ātiawa/Ruanui PHO and saw opportunities for better health and providing a template for the Taranaki DHB and PHO to follow
- Taranaki DHB needed to become more knowledgeable and involved in the configuration of dental services

Te Ātiawa Dental Service has developed a service that has the potential to go a long way to meeting the dental health needs of Māori and other disadvantaged groups in the New Plymouth area. However, to be able to build on the gains that it has already made and to provide a full and complete service will require overarching funding. That the Taranaki DHB would be in a position and a mind to do so remains in the future.

9.3.2 The passion

It took three years from the inception of the idea to establish a Māori dental service to its formal opening. That Te Ātiawa Medical Service was able to provide a dental service, albeit a limited service, as an extension of its own service provision, was due solely to the passion and commitment of those involved. Having to confront a high prevalence of dental disease in the patients who present at the dental surgery can be very discouraging for the clinician:

*With a Māori dental service you certainly notice the standard of dental work that has been done. I have to say that I have been saddened a bit by what I have seen.*

*For many of the patients, in the past, there has been no treatment options available*
for them. In the bucket and that was it. That led to an almost institutionalised mentality I suppose on the part of the patients. On the other hand there was a stereotyping by some dentists. Why bother to fix their teeth when they are not going to look after them.

However, being able to overcome the situation and provide complete oral rehabilitation, especially for those who may not have been in a position to access that dental care, is rewarding for all concerned:

A case in point. A patient said, “The dentist just ripped out my teeth. He (the other dentist) just assumed that that was what I would want. Well I didn’t want. I really wanted to try and keep my teeth. Okay, so I wasn’t the world’s best at brushing my teeth. But I never had anything explained to me; what I could have.”

Well now this patient is in my dental chair and we have a chat about all this and what we could do. We could save the teeth with root canal therapy and that’s what we did. It’s giving the patient the best treatment options available. I have to say the patient was pretty rapt with everything we did for him.

9.3.3 The future of Te Ātiawa Dental Service

Whilst Te Ātiawa Dental Service is able to provide dental care for those low-income patients funded through both WINZ and a DHB contract for emergency care, it is not an ideal situation. To expand their services and their client base will require security of on-going core funding. This will require a commitment of behalf of the Taranaki DHB. However, the staff and management at Te Ātiawa Dental and Medical Centres continue to plan for the future:
We were looking initially at caravans to provide a mobile service. But now we have gone past all of that. This is only after sussing everything out. You need a good base. That’s what we have here. It’s not perfect but it is adequate, for the moment. Te Ātiawa Trust have sold this building and another one they own on the other side of town. With the income from those two sales they have purchased a new building which is more centrally located. We will go there with the dental clinic and with hopefully an improved clinical situation.

The one factor that is uppermost in the delivery of Te Ātiawa Dental service is the *kaupapa*:

*The great thing about Te Ātiawa Dental Service, the great thing for our Māori dental health service, is the patients. They really appreciate what you are doing for them. They really, I mean really, express their gratitude.*

*It’s the kaumatua, the tamariki, that whole whānau thing.*

*It makes the whole thing so worthwhile. That about sums it up. Whānau.*
Chapter 10

The mainstream model: Te Whare Kaitiaki

10.1 Ngā Timatanga (The Beginnings)

The University of Otago Dental School is the only tertiary training institution for dentistry in New Zealand. Approximately 60 students are admitted each year for the four-year course following either a First Year Health Science year or completion of an appropriate degree. Patients choose to attend the Dental School knowing that their dental care may be undertaken by a student. A senior Dental School clinician stated:

At the Dental School we are dealing in the large part with solvable problems. Whereas with medical problems, they are not as solvable as that. We have solvable things that we can do. We can still make good upper and lower dentures; we can treat periodontal disease. But in medicine, if you pick up a patient that has diabetes, the only thing that is going to happen is that they are going to get worse.

Dental School staff were only too aware of the poor oral health of many Māori patients. A long standing clinical administrator had come to the conclusion that:

Some Māori people are behind in oral health. What are the reasons? Well I say diet for one. Too many sugary things and drinks. Then there is the cost. It is expensive I know and it goes back to the economics and being able to afford dental care. Travel is another thing. Many of your people don’t have cars so can’t get to a dentist. Then health and oral care may be
seen as something separate and I guess they may not see oral care as being important.

The existence of barriers for some Māori to access dental care was acknowledged, highlighting the need for the development of appropriate services. A senior clinician at the Dental School made the link between barriers to accessing dental care and oral health:

*Barriers? For Māori, in general terms, yes I think there are, but they seem to fit in with the socio-economic side of things. Children leaving school early and missing out on Dental Benefits to start with. If we were to run state funded dental services through to young adults, to say 21 years of age instead of to their 18th birthday, then really, most of them should be dentally stable. For the great majority, they would only require low cost dentistry for the rest of their lives. However, for teenagers who have left school and don’t access dental benefits, they are still in a caries susceptible environment and they still haven’t developed a sense of on-going dental care. They are going to be susceptible to periodontal disease as well. That’s what the dentist will pick up. If they leave school at 16 years of age and don’t seek care again until they are in their late 20’s with toothache, then more often than not it is too late. Thinking about that makes me want to weep. When they do come in again in their 20’s the extent of the dental problems are such that they need expensive dental treatment. And that’s when you’re stuck.*

There was a drive therefore to improve access for Māori seeking dental care at the Dental School. This was led by J Broughton (the author) who has both Ngāi Tahu and Ngāti Kahungunu iwi affiliations. He had graduated as a dentist in 1977 followed by a year as a dental house surgeon at the University of Otago Dental School. He then
established the Gardens Dental Surgery, a suburban dental practice in Dunedin, but continued to work part-time at the Dental School as a clinical demonstrator. In 1989 he was offered the position of lecturer in Māori health at the Dunedin School of Medicine of the University of Otago, a position which included a two-tenths teaching role at the University of Otago Dental School.

As J Broughton was active in local Māori community affairs, particularly as chairman of the Araiteuru Marae Council, the governing body of the Dunedin urban marae, he was often asked to speak at hui (gathering) on oral health. He was continually approached by members of the local Māori community asking if he could attend to their dental care as patients of the Dental School. He was frequently confronted with comments such as, “Okay, so my teeth are a mess. I know that and I don’t need to be told. I want to do something about it but I get put off because, well, I guess it’s just the whakamā thing.”

A number of Māori people expressed that they would be more confident in attending for treatment if their dental needs could be facilitated by someone they knew and who would be familiar with their approach to health and health care. A senior clinician responsible for the Diagnosis Clinic (which is responsible for the initial assessment of all new patients seeking treatment at the Dental School and for emergency dental care) commented on the responses of some patients who had sought treatment at the Dental School:

*I am aware that comments have been made from patients about how they have been treated in the Dental School in previous visits, not only Māori patients, but let me say, “of the less able people”. The whole thing is about making people prepared to come in to the Dental School for treatment.*
It is intimidating for a lot of people who come into the Dental School for the very first time. As patients, they are suddenly in an area with a lot of other people and they may not be sure of where they are going, what is going to happen and who they relate to. So it can be quite confusing for some people. Your people will feel that just as much as anybody.

Although many of the issues regarding the delivery of a Māori dental service that is based within a large institution such as a dental school may be very similar to other models of Māori service delivery, there are aspects that are unique to this model. These are now discussed with regard to development, implementation and operation of a Māori dental health clinic within the University of Otago Dental School.

10.2 Te Whare Kaitiaki Dental Service

10.2.1 The development

The development of an accessible and appropriate dental health service for Māori within the University of Otago Dental School is presented in some detail, as it serves to highlight a perceived difficulty that eventuated at the outset.

After J Broughton took up his full-time appointment at the University of Otago, he was entitled to access the Staff Clinic at the Dental School. Permission was granted from his Head of Department (HOD) to undertake an afternoon of clinical work. He approached the administration staff of the Staff Clinic and found that a Wednesday afternoon was free and available for his use. The clinic was subsequently booked for him. He informed the staff not to book in patients but that he would be responsible for organising the patient group himself. He also discussed the use of the clinic with the then HOD responsible for the Staff Clinic. In a subsequent letter from the HOD (18 July 1989) he was advised:
You will appreciate that the Faculty is in a privileged position with regard to patients and we must remain vigilant that established procedures are followed with regard to registration, referral and treatment of patients.

He was advised to write to the Dean formally requesting the use of the facility and to provide "some greater detail about your requirements" to the HOD. J Broughton complied with the requests and in responding to the latter, stated in a letter (10 August 1989):

Thank you for your letter regarding my request to treat patients in the School of Dentistry. I would like the opportunity to treat a particular group of patients at the School. The particular group I wish to treat are Māori and Polynesian people, who for various cultural and socio-economic reasons, have neglected dentitions. I believe that I could have a certain amount of success in changing the attitudes of an underprivileged group within our community towards improving their dental health.

The following reply (24 August 1989) was received:

TREATMENT OF PATIENTS WITHIN THE SCHOOL OF DENTISTRY

Thank you for your letter outlining your request to treat patients in the staff facilities within the Department of Restorative Dentistry.

Since you clearly indicate in your letter that you are focussing on a specific group of patients and offering primary care on a fortnightly basis rather than a full range of restorative dentistry, I consider it is not appropriate within the scope of the specialised facilities of the departmental staff suite.

I have discussed your proposal with [the Dean], and consequently suggest that you take up the matter of dental treatment for Māori and Polynesian people with neglected dentitions directly with him.
It was never indicated at any time that only “primary care” was to be offered. Three months later, J Broughton received a letter (27 November 1989) from the Department of Hospital Dentistry:

I believe you have been discussing the development of an oral health clinic for Māori patients.....as you will probably know, it has been suggested that the overall responsibility for the clinic should come within the Division of Hospital Dentistry.

I think it would be useful if we could meet to have some preliminary discussions about the proposals which you have and what facilities you would require to begin this clinic.

Following discussions with the Department of Hospital Dentistry and the Dean, a letter (6 March 1990) was received from the Dean stating that he would “take your request to the next meeting of the Heads of Department.” This was subsequently done and approval given “that a Māori dental health clinic be established in the School.”

In a letter to J Broughton (24 April 1990) the Dean commented:

I think this is a very worthwhile development and I would be grateful if you would let me know progress in about three months time.

In hindsight, it would have been easier to have approached the Department of Hospital Dentistry in the first instance, but this was not appreciated by anyone at the time. The new clinic began in the second term of the academic year in 1990 and since then continues to operate for one morning a week. It is staffed by a dental surgeon and as it has a teaching role within the undergraduate dental curriculum, two final-year dental students are assigned to the clinic each week on a roster basis.
Once formal approval had been given for a dental clinic to support Māori patients at the Dental School, it was necessary to plan for the implementation of the new service. A clinical administrator commented:

*I think we need to know what your expectations are of the clinic; what is the best for your patients, the students and the other staff that all work in the Department.*

Three issues evolved at this point: firstly, a name for the clinic; secondly, funding; and thirdly, the clinical facilities.

### 10.2.1.1 Name

The first issue that arose was a name for the clinic. Local **kaumātua** were consulted and the name “Te Whare Kaitiaki”, which translates as “the place of caring”, was given. Students and general staff however, referred to the clinic as “the Māori clinic”. A number of **kaumātua** who attended the clinic during the first two years liked to call it “Te Nihoniho Marae” This was a compliment, as the clinic became a gathering place for Māori patients to “catch up with each other and have a gossip”. The clinic found itself serving a social function in addition to providing a health service.

### 10.2.1.2 Funding

Unlike Tipu Ora Dental Service and Te Ātiawa Dental Service, funding for the clinic was not an issue. The dental surgeon’s salary was covered as he was a full-time member of staff. As the clinic had a teaching role, all costs for the clinic were covered within the Department’s budget. All patients who chose to access the service would pay the usual Dental School fees for treatment at the rate set down for the student clinics. These fees were considerably lower than what would be expected in private practice.
However, in 1994, the then Minister of Education, the Hon Lockwood Smith “cut state dentistry funding per student from about $40,000 to about $25,000, which was the medical education subsidy level. The Minister had not realised that Ministry of Education funding for medical education was actually boosted by a further Vote Health subsidy for clinical training” (Otago Daily Times 2001). This led to a dramatic rise in dental student fees and the risk that some Dental School community services may have to be cut. This put Te Whare Kaitiaki at some risk, so a contract was subsequently negotiated with the Southern Regional Health Authority (SRHA) for funding. This funding was included in the existing contract that the Dental School had with the SRHA, and was to cover the costs for treating a certain number of patients.

A conflict arose with the SRHA contract after 12 months when the returns (the reporting requirement) revealed that Te Whare Kaitiaki was not meeting its contractual obligations with regard to the number of patients being seen and treated. This, at first glance seemed odd as there was at no time, any ‘down-time’ in the clinic. There was always a patient in the chair. What was realised was that, because of the severity of the dental disease that presented in the patients at the clinic, there were fewer patients and longer appointments. Once this was explained, the requirement in the SRHA contract for treating a precise number of patients was subsequently dropped.

10.2.1.3 Clinical facilities

A one-chair clinic was made available on the first floor of the Dental School which was part of the Department of Hospital Dentistry. This was deemed to be adequate to meet the potential needs of the patient group within the local Māori population. Dental assistance was available as required from the Department’s pool of dental assistants.
10.2.2 The implementation

Once approval had been given for the new service, clinical facilities were identified and a designated time slot was determined. The clinic would operate every Tuesday morning from 10am to 1pm during the academic year. The new service was made known to the local Māori community through local community networks, and patients made contact for appointments. There were two particular issues that arose during the implementation of the new service. The first issue was positive; this was the introduction of a kaupapa Māori service within the Dental School. The second issue was negative, and that was racism.

10.2.2.1 A kaupapa Māori dental service

The question that was asked by a number of staff and students was, "What makes this service any different?" The answer was the delivery of a kaupapa Māori service. The aim of the clinic was to provide a non-threatening, Māori-friendly approach in order to improve Māori access to dental services at the Dental School. The idea was to achieve this through: the application of Māori values, beliefs and behavioural practices; te reo Māori; and the recognition of, and respect for, Māori identity in a clinical situation. Some strategies included:

- The expression "whānau concept" had become fashionable among Māori at the time. It was understood to mean that aspects of whanaungatanga would be incorporated into the delivery of a health service. Māori patients could, if they wished, bring whānau tautoko or family support with them into the clinic, or they could attend the clinic as a small family group. Many patients chose to do this.

- Many Māori patients would greet the Māori clinician in the traditional manner by shaking hands and hongi. Female patients would also kiss
the clinician on the cheek. Some staff, students and other non-Māori patients in the reception area found this disconcerting.

- The waiting room was often regarded as an intimidating environment and so many patients felt free to come straight into the clinic. As most of the patient group were well known to each other, this was accepted as normal social behaviour. The clinician was then required to monitor this behaviour to ensure that confidentiality was never compromised.

- Many patients preferred to bring a friend or family member to act as their own dental assistant, donning gloves, mask and gown. The interesting outcome of this was that the family support members would invariably deliver the dental health messages to the patient. Such comments as, “Oh, you’ve got this ugly hole in your tooth. That’ll teach you for eating lollies all the time!” were frequent.

- Taking the time to talk at length with the patients about the local happenings and current issues within the local Māori community was a very important strategy to reduce dental fears and for the patient to gain confidence in a clinical environment.

These small and seemingly insignificant strategies were very important for many Māori patients who attended the clinic. The important aspect was that Māori came to view Te Whare Kaitiaki as “their clinic”. A clinical administrator commented:

*I know the patients feel so much better in a friendly situation. Having the patients come with their own support people, whānau; that is something which is different from what most of us do when we go to the dentist. I*
can see the merits of that for some people. The day will come when they can feel they can come to the clinic on their own; when the people aren’t so dependent on others. It’s just a case of getting used to things, isn’t it.

10.2.2.2 Racism

This was an unfortunate and not unexpected occurrence. The nature of the racism exhibited was not overt racism nor was it institutional racism. It was personal racism manifested by the portrayal of negative attitudes by some staff and students and by specific acts of discrimination. The Waitangi Consultancy Group had developed the following definitions of racism (Waitangi Consultancy Group, undated manuscript):

**Racism**
When people of one culture presume their ways of doing things are common sense and ‘the norm’ and have the power to impose their standards and practices on people of other races and culture.

**Institutional racism**
The implementation of racism by organizations, institutions and agencies. This is done by carrying out policies and practices which operate to the advantage of the group who holds power and the disadvantage of other racial groups.

**Personal racism**
There is a personal aspect to racism which shows up as a prejudice or bigotry and leads to acting on the basis of negative stereotypes of other racial groups. It is expressed through acts of discrimination.

This was not an easy issue for the clinician to deal with and it took a considerable amount of time, patience and diplomacy. The following were examples of personal racism which occurred:
1. Some students came to the clinic with very negative attitudes which were demonstrated by asking disparaging questions in a demeaning manner. A senior clinical administrator who was asked about this stated:

   Yes, I would have to agree with that. I have been here working at the Dental School for quite some time and I was here when the clinic first got going. What I have seen is that with many of the students and their ideas, they are either black or white; there is no grey.

The questions posed by some students in challenging the establishment of the clinic, and the clinician’s responses are as follows:

   “Why should Māori be given special treatment with this sort of clinic?”

Māori were not given “special treatment”. The Dental School had a number of special needs clinics such as a Temporomandibular Joint (TMJ) Clinic; a traumatised teeth clinic; a facial pain clinic; a medically compromised patient clinic; and a clinic for intellectually disabled people which were all designed to meet the specific needs of specific patients. When New Zealand accepted refugees from Kampuchea in the 1980s, those living in Dunedin chose to access dental services at the Dental School. Because of the language barriers, they were all catered for initially within the Department of Hospital Dentistry and not in the Dental School’s student clinics, in order to ensure that their dental needs were attended to in the most appropriate manner.
"Why should Māori be given free treatment when all other patients have to pay?"

This was not true. All adult patients who seek dental care at the Dental School are required to pay for dental services received.

"Why should Māori be given preferential access to treatment over and above everyone else?"

This was not true. The Dental School was responding in a pro-active manner to meet the dental health needs of Māori people who chose to access this service.

2. Some students refused to participate in the clinic altogether on the mistaken perception that this was a blatant example of apartheid.

Nothing could be more further from the truth. Apartheid (Waitangi Consultancy Group) is "a political system where one race which holds power strictly enforces total separation of different races, in order to maintain power." A Māori health service is not an example of apartheid.

By way of explanation for the behaviour of a very small number of students, the following kōrero was given by a clinical administrator:

When they (the students) come to the Hospital Clinic for the week on roster they already have fixed ideas of what they want to do; they either want to do this or do that, or they don’t. They want to do oral medicine and oral surgery, treat individual needs patients,
the TMJ clinic or emergency care patients on casualty. At the end of the day all they want to do is get through the clinical work and graduate. They don’t want to do anything else but graduate.

However, other students were positive about participating in Te Whare Kaitiaki:

On the other hand there are many students who are absolutely enthusiastic about everything. They want to be involved with everything that’s going on in the clinic, including the Māori clinic. You certainly get plenty of students who are very keen to take part in the dental programme at Rotorua.

3. Te Whare Kaitiaki was a teaching clinic with treatment being undertaken by students. It was therefore regarded by the administration as a student clinic and the fees charged out at the student fee rate. The Dental School has a hierarchical system of fees: student fees, which are the lowest; staff fees; and specialist fees, which are the highest fees charged. However, when the initial group of patients who attended the clinic received their account in the post they had been charged out at the specialist fee. When the patient complained to the clinician regarding their “exorbitant bill” and the complaint investigated it was clear that an administration staff member had billed Te Whare Kaitiaki patients at the highest rate of specialist fees. This was rectified with the Accounts Section. This did not occur again after the particular staff member responsible for entering the fees was no longer employed by the Dental School.
J Broughton was responsible for the teaching of a module of culture and health within the final year paper, DENT 511 Community Dentistry, which afforded him the opportunity to present and discuss Māori oral health service provision to the students. However, this did not appear to vanquish the negative attitudes of some students. It was later revealed that some general staff “fill up the heads of the students with all of that stuff about the Māori clinic.” A senior clinician stated:

_The dental assistant, that is the normal telegraph system here._

That racism existed was not denied. It was explained through a lack of understanding:

_I would put that down to one word, and that’s communication. Speaking purely from the Dental Assistant’s point of view, there wasn’t any communication. In fact, people felt that there was no problem in having a Māori clinic, but it was not knowing why it was there or why there was a need for a Māori clinic._

J Broughton was invited to discuss the issues of Māori oral health service provision with the general staff at an in-service training session:

_However, when you came to speak to the staff at our in-service training, that made all the difference. You explained about how Māori people feel; about their health; about their body and about how Māori people like to be, with their family and that. You also explained what you were trying to achieve. And that was great. There was a greater understanding and everyone was quite happy after that. It would be good for you to do that again; I think it’s timely now for that to happen once more; perhaps in the New Year._

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In the midst of the racist attitudes during the first years of the clinic, a situation occurred which gave rise to a formal complaint. In 1991, after the clinic had been in operation for almost a year, the local newspaper ran a page-three story about the clinic under the head-line: “Family slant for Māori dental clinic” (*Otago Daily Times* 1991):

Making dental services more Māori-friendly is one of the aims behind New Zealand’s only Māori dental health clinic, operating at the Otago School of dentistry.

The clinic was based on a “*whānau*” (family) concept and patients were encouraged to come in with family members. This created a more social and “laid back” atmosphere which was less intimidating…”

The article was accompanied by a photograph of a patient in the chair who had brought along his own *whānau tautoko* (family support):

> Mr John Broughton (left) gives Mr Arran Pene a dental check-up, while the patient’s rugby mates, Mr Steve Renata and Mr Phil Dunn help out.

It was later revealed that a letter of complaint had been sent to the Dean following publication of the newspaper story: A senior dental assistant commented:

*There was also the issue of standards, clinical standards. The reason behind the letter going to the Dean was because of the photograph that appeared in the paper. It was felt that clinical standards were not being adhered to and that the role of the dental assistant was undermined.*

A print of the photograph which had been autographed by Arran Pene as New Zealand Māori All Black Captain together with a copy of the story was framed and hung on the wall of the clinic. Whilst the letter of complaint was not an act of
discrimination, it illustrated some ill-feeling towards the clinic. This is the only view that can be taken as it was never raised directly with J Broughton who was completely unaware at the time, that any letter had been sent.

Manifestations of racism have appeared on occasions within the Dental School, directed in the main towards the large number of dental students who were not born in New Zealand. J Broughton was confronted with a racist slogan intimating that Asian students were not welcome, scrawled in indelible ink across the white board of a lecture theatre as he was about to present a workshop to the fifth-year students in March 2004. Three other similar slogans had appeared at the same time in other parts of the Dental School. The person or persons responsible were never identified.

In an effort to overcome racism, a half-day workshop on celebrating ethnic diversity was introduced for the fifth-year students in the Community Dentistry course. This session has proven to be very popular with the students.

10.2.3 The operation

Once the clinic was in operation, there was little doubt about the need for the service it was providing. A senior clinician was very supportive in the comments she made:

_Te Whare Kaitiaki seems to work; it is used; it is busy. The fact that there seems to be very little if any downtime in the clinic doesn’t surprise me at all. Seeing patients as they come in the door to the Dental School, many of them are aware of the clinic. That it operates as a clinic for Māori is known out there in the community. The word on the street is that we can go there, because John is there._

It also meant that patients were being offered a choice of service:
Some people (who have come through Diagnosis Clinic) do ask, how do you get an appointment? How do you access the clinic? Other patients are not particularly interested; they have decided, no I don’t want to go there. To have the clinic explained to them… they have thought about it a bit more and still say, no.

The one key element in the operation of a new kaupapa Māori service within the Dental School was the management of the clinic. To provide the best possible service appeared on the surface to be something that would be quite straightforward. However, as it turned out, this was not the case. The role and function of the clinician responsible for the clinic was central to its operation. What eventuated was that the clinician became a facilitator and was the interface between the Department of Hospital Dentistry, the students, and the patients and their whānau. Firstly, the management of the clinical facilities was critical, as on occasions they were stretched to cope with the demand for services. Secondly, the requirements of the Dental School administration had to be strictly adhered to. This involved the correct procedures of patient enrolment and the maintenance of dental records, the maintenance of clinical standards, and ensuring that all clinical procedures and processes were adhered to. Thirdly, it was necessary to ensure that the needs of the students were met. The clinic was a teaching clinic and it was important for the students to feel that they could actively participate rather than be passive observers. The students therefore engaged directly with the patients and undertook the clinical work that was required. Fourthly, it was important that the needs of the patient and their whānau were met. It was necessary to provide an atmosphere and environment that was welcoming, non-threatening and “Māori-friendly”. To accommodate these four aspects at one and the same time was, in the main, all part of the way services are provided within the Dental School. However, at times, it was very stressful for the clinician to actually oversee these aspects in practice. Whilst it may have appeared
that management of the clinic was running smoothly, it took immense tact and
diplomacy on behalf of the clinician to maintain this façade. A senior clinician stated:

*Within the university system, we see a lot of people as patients who are*
in some type of training themselves. *So they are very aware of what is*
going on. *Whether it is this variation of patients compared to the patients*
you may see elsewhere, or getting our students tuned up to the fact that*
these patients are very aware of what is being done dentally, does*
become very tense. So there are two things going on. Firstly, the patient*
who is very aware of everything that is happening and secondly the*
dental student who has to understand that the patient knows and*
understands what is happening. They (the patients) have survived and*
the students should survive it too.*

10.2.3.1 *Managing the clinical facilities*

The one-chair clinic that was made available was more than adequate to accomplish
the clinical services that were to be provided. However, on occasions, the *whānau*
tautoko that arrived with the patient and the number of patients who came, “because I
knew so-and-so was coming and I wanted to catch up with them” made for a large
number of people being present at the same time. Some patients who had completed
their appointment also tended to stay on to “awhi (support) my mate here.” A clinical
administrator commented:

*In the meantime of course you do not have enough room in the clinic;*
*the size of the room is too small to accommodate the patients and the*
*visitors that come with them, plus the clinical staff and students.*

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It was fortunate that extra dental chairs were available for use in the adjacent clinic which could accommodate the overflow of patients. In a teaching clinic, the normal practice was to have one patient for a 60-minute appointment, which would equate to three patients in a morning clinic. What was happening was that up to four times that many patients arrived, some without an appointment, whilst other patients had been booked in by reception staff. A Māori postgraduate student was assigned to assist with the additional patients in the adjacent Hospital Clinic, which worked well for the two-year period of his course. The flow of patients to the clinic is managed very well now to avoid the congestion that occurred in the initial years of the service. A senior dental assistant commented:

For the clinic, ideally it would be a lot better to have a larger area; a more suitable area where you could have more people. This is a good clinic for what it is but at times it may be a bit small for you for the number of people who come. So by the time there is the patient, and perhaps their whānau as well, you and the dental students, it does get a bit crowded. It would be good to have a dental assistant as well to ensure the standards of care, cleaning up and cross-infection.

10.2.3.2 Managing the administration

The administration of Te Whare Kaitiaki involved managing the reception of the patients on arrival, the waiting area and the maintenance of the patients’ record file.

The reception is usually the first point of contact between a patient and the health service. No matter what the nature of the service may be, it always requires careful management. It wasn’t so much the management of the patients upon their arrival at the reception desk, but the management of the reception staff themselves, that was important. A clinical administrator stated:
The clinic reception desk: People will come in off the street and ask for you. Your people seem to come in with pre-conceived ideas about things and we cannot always deal to that. For example, when our staff run the reception desk, and we all do it at some stage, well we don’t know whether to book the people in to the Māori clinic, whether to take their name and address or phone number and say you will get back to them, or to see them through the diagnosis/casualty clinic. We are not sure how to manage the patients as they walk in off the street. As we no longer have the diagnosis clinic now it can be a little more difficult when the people ask, “How do we get into this clinic? – the Māori clinic that is”. Many people who walk in off the street certainly know about the Māori clinic.

An apparent difficulty in the management of the reception occurred when a temporary receptionist was assigned to the Hospital Dentistry Clinic when the Department receptionist was on sick leave. The temporary receptionist made it quite clear that she was “absolutely terrified of having to speak to those Māori patients.” She maintained that she “did not know what to say or how to speak to them.” The clinician was bewildered by this response and after attempting to reassure the receptionist that all she had to say was, “Hello, can I help you?” there should not be any difficulties. However, she was adamant that she was “absolutely terrified.” As it eventuated, there were no difficulties. The clinician made a point of keeping a watchful eye on the reception area when the clinic’s patients were likely to arrive. This particular situation revealed the existence of some antipathy towards Māori.

The waiting room is another aspect that required careful management:

On the first floor here we have a shared waiting room. It is the waiting room is for casualty patients; for new patients coming into the school
for the first time; for dental hygiene patients; for emergency care patients; for Temporomandibular Joint Clinic patients; for individual needs patients; and for your patient for the Māori clinic.

Difficulties have arisen when some patients, who may have been waiting for up to two hours, see other patients arrive and be admitted to a clinic immediately on arrival.

Well some people get very annoyed. They get annoyed when they may have been waiting there for some time and another patient arrives and goes straight in. They don’t realise that it is a shared waiting room. So we have put a notice up about that and that has made a difference.

Maintaining the patients’ clinical files is imperative. This can be a very time-consuming process. The normal Dental School procedure is for new patients to be seen in the Diagnosis Clinic, but some new Māori patients preferred to come directly to Te Whare Kaitiaki. It was essential that these new patients were correctly enrolled at the Dental School and the consent forms had been signed. This was also the case for the children from Te Kura Kaupapa Māori O Ōtepoti (the Māori immersion primary school in Dunedin) who utilise the clinic. Their enrolment and consent forms are required to be sent back from the parents via the school. On occasions, this does not occur, and it takes considerable time and effort to ensure that the forms are completed by the patient’s parent or caregiver and returned so that the required administrative procedures are followed through. Maintaining a track on the patient’s file is also important when they are referred to another department for specific treatment. Failure to do this can delay treatment as the following case illustrates:
Case history

The patient was a five year-old girl who was a new entrant at Te Kura Kaupapa Maori O Ōtepoti. On examination she was found to have 17 carious lesions. She had not accessed any dental treatment as a pre-school child. The best way to treat her was to have her restorative care undertaken under a general anaesthetic. This was duly arranged through a referral to the Department of Paediatric Dentistry. As it turned out, her treatment was delayed for five months. This occurred through two files being generated for the patient under different names. When she first presented, an original file was generated after the enrolment forms had been filled out by one parent. When she was referred to Paediatrics she was accompanied by the other parent who had another file generated under the second parent’s name. It took five months for the two separate files to end up on the same desk at the same time to realise that this was one and the same patient. When the two files were merged the procedures were then implemented for the treatment to be undertaken under a general anaesthetic.

One other important aspect of administration was the appointment book. The clinician deemed it important that he control this to ensure that the clinic was not booked up too far in advance. When this occurs, failed appointments always occur as people forget if their next appointment is in six weeks’ time. Every effort is now taken to keep the appointments booked for only one week in advance.

10.2.3.3 Managing the students

It is essential that the needs of the students are met. With the Dental School being a teaching institution, it is important that a positive clinical learning environment is maintained at all times. The intention was for the students to gain clinical experience through interaction with a section of the New Zealand population who: have a specific view of health and well being; have a unique social structure and organization; and have particular health and dental health needs. A senior clinical teacher commented:

*Te Whare Kaitiaki is very good for our own students because they do not feel threatened going to work there. They are not going out somewhere*
on their own; the clinic is still in the Dental School building with a structure and organization that they are familiar with.

One strategy that is commonly employed is that the clinician will engage in conversation with the patient about a whole range of Māori health issues from family health to smoking cessation, with the intention that the students will learn about the wider issues affecting the health of Māori by osmosis. Discussion of a particular case frequently occurs with the students after the patient has departed in order to highlight matters of a specific cultural nature.

By fifth-year, the students are generally very good at upholding and maintaining their clinical responsibilities. Even so, this has to be monitored by the clinician. A clinical administrator noted that:

*Sometimes the students are just not up to scratch when it comes to maintaining the proper clinical protocols and cleaning up after themselves. We do try to assist when we can but we are short staffed ourselves, and as you know yourself, the place can really get just so busy. So a dental assistant would be something to have on the wish list.*

As the students have very diverse backgrounds, with the majority now not being New Zealand born, the issue of cross-cultural communication and interactions can create interesting situations. A senior clinical teacher commented:

*In the case of young people, teenagers, we are dealing with the disease, dental disease, when it is developing. It is seen at a time when the profile of health science students is changing. We are much more multi-cultural now than when the clinic was established 14 years ago. Many of the dental*
students (who were not born in New Zealand) may have a very protected life. They come here to go to university. Their family background may be that dad is at home in Taiwan and mum is here looking after a number of children. They are not flatting; they are at home with mum and have quite a subdued life. They are here to study and to pass exams. As a staff member, they are the ones who take a lot of effort; for the students to give a wee bit of themselves takes a lot of effort on our behalf as staff. They have strengths and weaknesses right across the board. So when we have the situation when the patient is not too sure what is going on, and the student is not sure what is going on, then we have a situation which does get quite tense. It is managing that which can be quite tense.

Such scenarios merely add to the stress of the clinician. However, on the positive side an interesting interaction occurs very frequently between the children from Te Kura Kaupapa Māori O Ōtepoti and some overseas students. The children are never backward in asking the student, “Are you Chinese?” The student may reply, “No, I am Korean.”

“Well, how do you say ‘hello’ in Korean?” asks the child. What follows is a two-way interaction in which the student teaches the young patient greetings in their language while the child will teach the student how to say greetings in te reo Māori. Any barriers in communication are rapidly dissipated and the student is able to complete any clinical work having gained the total confidence of the patient. However, in contrast to this particular scenario, one patient had another viewpoint of cross-cultural communication which was recalled by a senior clinical teacher:

A patient we had works with a Māori provider. She was in the clinic and the student I had with me was chatting away with her and must have said something about Te Whare Kaitiaki clinic. This particular
student, an overseas student from China, was interested in special needs dentistry. I recall very clearly the comments that the student said to the patient about coming from a different culture. She said, "You must be very confident in your own culture in order to deal effectively with people from another culture." The student said she was going to learn Māori language because she wanted to get involved in public health dentistry and interact with Māori. The patient said to the student, "If I were you, I wouldn't do that." Her argument was that the student could do more for her own people. The patient saw things quite differently from the student.

10.2.3.4 Managing the patients

This could be regarded as the most important aspect of all. There is a wide diversity of patients who seek care at the Dental School with a wide diversity of individual oral health needs. A senior clinical administrator commented:

On occasions I've seen a few patients that have come through the casualty clinic and I have had the right to ensure that the patients are followed through. Something that I have seen is that the clinician treats the tooth and not the patient. Because the patient has had to have that tooth out, or that tooth dressed, well that is all that the clinician does; they don't want to look at anything more. The patient may need to have to go on to have endodontic treatment but this may occur without any other discussion about that, or any consultation about treatment options. When the patients are seen at Casualty Clinic the clinicians should do a more cut and dried treatment plan for them, rather than as I said, just treat the tooth. Not all the dentists offer treatment options as to what could be done. So for
Within the first two years of operation of the clinic, four specific issues were identified with regard to the management of the patients. These were: firstly, the severity of the dental disease that presented in many of the patients; secondly, the number of patients who were medically compromised; thirdly, the dental fears of the patient; and fourthly, the affordability of the service for the patient.

(i) Severity of dental disease

The dental disease that was evident in many of the patients who sought treatment in Te Whare Kaitiaki was often very extensive. Both severe dental caries and severe periodontal disease was not uncommon reflecting many years of dental neglect. A typical patient was a male, aged mid-to-late 20s who had not accessed dental care under the Dental Benefit Scheme or had not had dental care since leaving school. He had eventually sought treatment as a result of dental pain. In many cases, extraction was the only option. Anecdotal evidence of such clinical presentations had been described by Broughton (1993b, 1995a, 2000c). Some patients who had presented for relief of pain would have their immediate needs attended to, followed by a discussion about long-term dental options and rehabilitation. An appointment would be made for a follow-up appointment but the patient invariably failed to keep that appointment and failed to respond to any further appointments. On the other hand, there were other patients who responded very positively to dental treatment and were very happy to undergo a full course of dental treatment and rehabilitation. The treatment plans of many of these patients included endodontic therapy (especially on first molars) in order to restore the dentition. As many as six one-hour appointments were needed to accomplish this, which was time-consuming and required considerable clinical skill and expertise.
The prevalence of periodontal disease which presented at the clinic was also extensive. Prevention of periodontal disease was raised as a concern which highlighted the importance of an appropriate and accessible service for Māori. A senior clinician expressed the following view:

*Dental hygienists provide a very important role in treatment. Access by Māori to a dental hygienist makes them aware of periodontal disease, that otherwise, in general does not occur in some of the other health provider schemes. I have reservations about dental therapists treating teenagers unless they have undertaken a full up-skilling in their training. When dealing with Māori teenagers, I see that many of them are developing periodontal disease and it is not being treated. I don't want to be critical of the school dental therapists but they are trained to treat primary school children and intermediate school children. If their treatment practice is extended to secondary school children they will experience having to treat teenagers with periodontal disease. Therefore, they will need to increase their treatment (scope of) practice. It is not so important whether it is the dentist or the dental hygienist that is doing the work, but that periodontal disease is picked up and treated.*

Many of the new patients at the Dental School may first be treated by the hygienist in the Department of Hospital Dentistry before being referred to Te Whare Kaitiaki.

(ii) Medically compromised patients

The number of medically compromised Māori patients who presented seeking dental care in the first years of the clinic was noticeable. The two main disease indicators were rheumatic fever (for which antibiotic cover was prescribed) and Hepatitis B (which required strict cross-infection prevention protocols to be adhered to). The
Hospital Clinic has an Individual Needs Clinic for the latter where these patients were referred for their dental treatment. What has been very obvious over the last seven years has been the marked reduction in the number of medically compromised patients presenting at the Dental School and in Te Whare Kaitiaki. A senior clinician had observed that:

For medically compromised patients such as those who are Hepatitis B or Hepatitis C positive, immunization has had an effect. There is now much more immunization of the public. More has been done in this regard. As a result we are now seeing a decrease in the number of such patients coming through the Dental School. There are definitely not as many as there used to be. Take the East Coast of New Zealand for example where there has been a really aggressive immunization programme happening up there. These programmes are reported to be working and it would seem so. We are now picking up the benefits of that. It is the same with rheumatic fever. Young adults, for example, patients on long term penicillin; we do not see as many of these patients now that we used to. Although the situation is not perfect, a lot more has been done in the public awareness of rheumatic fever. There are more public health nurses doing a lot more work in this area, especially with regard to following up on patients and their illness.

The drop in the number of these medically compromised patients can only be a reflection of the success of immunisation programmes not only for Māori, but for the whole population. Other medical conditions which presented in the patients at the clinic were maturity-onset diabetes, respiratory diseases and coronary heart disease. A number of tāngata whaiora (Māori mental health patients) also chose to access the service following the closure of Cherry Farm. The clinical administrator commented:
In the Individual Needs Clinic we now have 400 patients on the books but we only have 31 days available in the year to treat them. Patients who attend this clinic include patients with blood borne diseases such as hepatitis carriers, mainly Hepatitis C and HIV positive patients. We do have Māori patients in the Individual Needs Clinic. In the last few years we have had many people through the clinic and some of them have been referred to other clinics within the school. I feel that some of these patients are not being treated and are sent back to this clinic with, “Well that clinic is there and that is where they should be treated”, or, “It’s not our job to treat these patients.” Patients are given a choice of where they can go to be treated. Some want to stay with the Individual Needs Clinic, others may want to go to the Māori clinic and that is their choice. I think that is good; a patient’s choice is important.

(iii) Fear of dentistry

Māori patients, just as much as any other patient, have fears about dental treatment. Patients accessing dental care at Te Whare Kaitiaki were no exception. The clinician responsible for the Diagnosis Clinic commented:

*The key is to make the whole area more friendly. The Māori patient who would come in and knows the system, that is, how the Dental School functions. They may have said that coming here wasn’t all bad, so they will continue to have treatment with the Dental School. They know that you’re there in case. They may not be seen or treated in Te Whare Kaitiaki but they know you, and know you are there if need be.*

Responding to the dental fears of patients who present for treatment within the Dental School requires careful management because it is not only the clinical environment
and the clinician that the patient has to encounter, but also the students. This is not necessarily an additional negative aspect that has to be contended with for, by, and on behalf of the patient. It can often be quite the opposite, as one clinical teacher noted:

Fears of dentistry; that is something that is across the board. What is interesting is that in many cases the patient is more likely to own up to a student that they are scared. That is because they see the student as being friendly whilst the dentist can be seen as being scary. In my opinion, women in dentistry are not disadvantaged. In fact quite the opposite. Patients will say things to me that they wouldn’t say to a man. Exactly the same thing applies to students. The patients often say things to a dental student that they wouldn’t say to the dentist. That is because the students don’t scare the patients a bit. I think that third-year students are the best ones of all in calming a scared patient. Both are scared so they don’t end up doing a lot together.

One of the manifestations of dental fears by a Māori patient is whakamā. The patients may appear to be unco-operative, very reticent in their communication, and withdrawn. The management of a patient who is whakamā can require considerable skill, expertise and compassion as illustrated by the experiences of one clinician:

I have dealt with some cases, not a lot. I think it is a two-stage recognition. In the first instance the patients are just scared. They are not sure of their ground here at all. Then after a while that goes and they are not scared. They ease up. If there is no change at all, the dialogue is not happy. That is where I have got stuck. Sometimes you are just stuck. Sometimes the patient will say something that will let you try again. If that doesn’t happen I would ask the patient, “What’s wrong?” Or I
would ask, “What can I do to help you?” Sometimes you have to stop and ask the patient to come back on another occasion, or ask someone else to see them. You do tend to go in several times to try and find out what the patient wants and generally there is no problem. But if that doesn’t work the only thing is to have the patient come back again another time.

Te Whare Kaitiaki has had a number of very difficult cases to manage. They were all males, aged in their 30s, and were all very aggressive. They all used abusive language and in extreme cases were threatening to the clinical staff. On such occasions senior clinical staff were called in to assist with their management. These patients were referred to the care of a senior clinician within the Dental School or advised to seek treatment in private practice. The aggressive behaviour was seen as a manifestation of dental fears. The management of such cases merely adds to the stress of the clinician.

(iv) Affordability

Many patients who seek dental care at the Dental school do so knowing that the fees charged are far less than what they would expect to pay in private practice. Many Māori patients also choose to attend the Dental School for this reason. Even though the fees are low by comparison, the Dental School experiences bad debts. Dental School patients who have been remiss in paying their accounts have their record file stamped “CREDIT STOPPED” in large green ink on the cover. A number of patients who have been treated in Te Whare Kaitiaki had their file stamped in this way. A senior clinician was very familiar with the problems of non-payment of fees by the patient:

Yes, this is so. This goes back to the severity of the disease. Patients who I said were “of the less able” are more inclined to have a more severe disease state and therefore may require more extensive
treatment. The Emergency Dental Care Clinic has made a difference and WINZ has made a difference there as well. I think the WINZ Office in Dunedin is very understanding. They’ve got their clients and they know that their clients who come to the Dental School for treatment are getting value for their money. WINZ appreciate the need for emergency dental care. The WINZ officers are pretty good at allowing that money to flow through. In a student clinic $300 will cover the cost of 6 fillings which is a long way to getting a mouth sorted out. In private practice all $300 from WINZ will get you is two extractions; and that is all the patient is going to get.

Te Whare Kaitiaki clinician has been subject to comments such as “Your patients again”, or, “It’s always your patients who have the green stamp” , in a very derogatory tone by some general staff when referring to patients with outstanding accounts. The Dental School policy was that any further treatment was not permitted until an outstanding account had been paid. In the main, the clinician was able to discuss the matter with the patient and any arrears were subsequently attended to.

Some Māori patients who sought dental care at the Dental School were treated in the Emergency Dental Care Clinic. The treatment is provided by staff rather than by students with their treatment costs covered by funding from WINZ:

The Emergency Dental Care clinic offers complex treatment for $35. We’re saving teeth for $35. For the patient, WINZ will at times pay that for them. The Dental School Administrator works magic at times. He doesn’t want bad debts. He is very helpful to people who don’t have disposable income. Unfortunately there are too many people in that situation. He provides budget advice. He is prepared to allow the
patients to pay at the rate of $5 per week. He much prefers it if people pay $10 a week. He goes out of his way to help the people; he actually does more than his job description. As long as the patient pays something, they can get back into the system and continue with their treatment. Under the emergency care for low income patients they are only entitled to treatment for relief of pain. We don’t do anything else, that is further treatment, until the situation arises when things get worse.

The Dental School has developed very good relationships with WINZ to ensure that cost are covered for dental treatment for eligible patients. A significant number of Te Whare Kaitiaki patients have treatment covered by WINZ funding. This can be an added administrative step for the clinician to ensure that a patient receives the benefits that they are entitled to.

Managing the patients will always be the primary concern to ensure that the best possible service is provided, the needs of the patient are met, and the best possible treatment outcomes are realised.

10.2.4 Other considerations
In the 15 years that Te Whare Kaitiaki has been in operation, there are a number of other considerations that are worth noting:

10.2.4.1 A visible Māori presence within the Dental School
The clinician felt that, although Te Whare Kaitiaki had been established, it was important to maintain a visible Māori presence within the Dental School. This was achieved through the framing and hanging of oranga niho promotion items and
photographs on the walls of the clinic. In 1994, the clinic achieved national recognition by being awarded a Certificate of Commendation from the Minister of Health at the Māori Health Decade Hui. This award adorns the wall of the clinic along with framed photographs and newspaper articles of dental students who had participated in the dental health project at the Tūnōhopū Marae at Ōhinemutu, Rotorua over the years. A senior clinician commented:

_They are great because they are real recruiting photographs for dentistry. The students are very good at getting people involved in dentistry and the Dental School. This is because they are so enthusiastic. The photographs do draw attention to the Dental School being out there in the community._

The clinic is used by other specialist clinics and other groups of patients. The photographs and pictures have not gone unnoticed according to a clinical assistant:

_The photographs on the clinic walls. People do comment about them, especially the well-known identities, They will get up and go over and have a closer look and read the articles about the pictures. They do seem to create quite a bit of interest with some of the patients. It was really interesting that some of the patients who are seen in that clinic have said things like, “Well why aren’t we represented on the walls? Why aren’t our pictures there too?” These are patients who are individual needs patients; they may be hepatitis positive and have a history of drug use. One patient said that if they were pictured on the wall that “that would be something to showcase because after all, I have found that there is life after drugs.” I thought that was a very positive response for that person._
10.2.4.2 An evaluation of Te Whare Kaitiaki

In 1992, a group of Trainee Interns (6th-year medical students) undertook an evaluation of the clinic as part of a public health project within the Department of Preventive and Social Medicine of the Dunedin School of Medicine (Jackson et al. 1992). The main conclusion of the evaluation was that "the Māori Dental Health Clinic is achieving its aims. The clients that have used the clinic find it a more acceptable form of dental health care than their previous care." The report made the following recommendations:

(a) Increase advertising of the clinic. As seen, word of mouth is at present the most effective means of informing people about the existence of the clinic. However, we also feel if wanting to reach a broader audience, the media should be better utilised.

(b) Increase the number of days the clinic runs. This would allow improved availability to those who already attend as well as greater accessibility to those who may want to attend.

(c) The question of more Māori staff was raised. This most certainly is determined by the number of Māori students in the dental school but it is clear that some Māori people expect more Māori involvement. This may aid clinic care in that a dentist may be able to empathise and communicate better with Māori clients in terms of immediate as well as preventive care (education).

(d) Improve physical surroundings – people have asked for a "pastel paint job", some music and some interesting posters.

To respond to the recommendations:

(a) Advertising of the service was done with a brochure that was distributed to local Māori health providers and the Māori Centre of the University. This has been very effective with increasing numbers of clients accessing the clinic through this means. This was especially the case for Māori students.
(b) It has never been possible to increase the number of days the clinic runs. This is due to the non-availability of clinical facilities, as they have always been very heavily utilised, and the lack of available time by the only Māori member of staff.

(c) The increase in Māori staff at the Dental School is welcomed. With the increasing number of Māori students now undertaking dentistry, the eventual flow-on effect with an increase in Māori staff will be inevitable, although it will take some time.

(d) The physical surroundings have been improved with the hanging of framed oranga niho items on the wall. There is now no more wall space left in the clinic. There is also a radio in the clinic.

10.2.4.3 Staff development

The University of Otago has a policy of supporting staff who wish to learn te reo Māori. The Higher Education Development Unit also run courses for staff on Māori pronunciation and the Treaty of Waitangi. A senior clinical administrator commented:

The general staff of the University are able to attend Māori language classes. I wanted to do that but when I applied some other people asked, “Why do you want to do that for?” I take pride in being able to say people’s names correctly. I went to the first te reo Māori class for the University staff and then I wanted to go the advanced class. So I am going to do the advanced course. I was brought up in a place where there were no Māori people at my school, so I did not grow up with Māori people around. I enjoyed the te reo class very much. The chap who took the class was very friendly, laid back, wasn’t demanding and was very professional. I also went to the language laboratory as part of the te reo course and that was very good too.
So I think that making the effort to learn the basics of the language and to pronounce people’s names correctly, or as best as I can, helps to make people feel more at ease. It makes things very welcoming for patients as many are very anxious. It’s great when a patient says, “Thank you, that’s the first time I’ve ever had a dental appointment and have not been scared.”

10.2.4.4 Links with the Tipu Ora Dental Service

A programme was instituted whereby a group of final year dental students participate in a week-long Māori dental health community project with Tipu Ora Dental Service at the Tūnghopū Marae in Rotorua providing some basic dental care to adults. This programme has been very successful for both the patient group and the students. However, participation in such a project would not sit well with all students as was pointed out by a senior clinician:

In contrast, (to being at the Dental School) the Rotorua experience is quite different. The students who go to Rotorua always return saying how much they enjoyed the experience, but this would not be the case for the whole class. Other students would not have the confidence to go to Rotorua as it would be too much of a change to what they are used to.

Nevertheless this programme has always generated considerable news media interest with items appearing on network television news, Te Karere (Television One’s Māori News), Māori radio stations and the newspapers. The relationships that are developed and maintained between the University of Otago and Māori communities, such as this particular case, uphold the obligations of the University of Otago with regard to the Treaty of Waitangi.
10.3 *Te kōrero* (Discussion)

Te Whare Kaitiaki is no different to Tipu Ora Dental Service and Te Atiawa Dental Service, with its aim of providing a *kaupapa Māori* dental service for the improvement of Māori oral health. The two issues that were critical for the successful development, implementation and operation of Tipu Ora Dental Service and Te Atiawa Dental Service were the relationships that were developed between the respective service and the stakeholders, and the commitment of the personnel involved. Te Whare Kaitiaki was no different in this regard.

10.3.1 The relationships

Over the years, Te Whare Kaitiaki has built excellent relationships within the Dental School to ensure that a *kaupapa Māori* service can function both effectively and efficiently. That it has been able to be established and maintained is due to the support and encouragement from the Department of Hospital Dentistry. Without this support it could not have eventuated, nor could it function. The support, advice and guidance that it receives to handle many of the difficult cases is acknowledged. The support and co-operation from other departments when patients require specialist advice and treatment has been exemplary. On occasions, some children from Te Kura Kaupapa Māori O Ōtepoti may require their dental treatment to be undertaken under general anaesthesia. The Department of Oral Surgery has always been very helpful in ensuring that this is effected without delay, and always within a week. There have been many reports (Te Tau-Pringle 1997),¹ of children having to wait up to six months for dental care under general anaesthetic but this unfortunate situation has never been experienced by Te Whare Kaitiaki patients.

¹ Personal communication. H Trengrove, Capital & Coast Child Health Summit, Porirua, 2 April 2004.
Excellent relationships have also been built and maintained with Māori communities, locally, regionally and nationally. Local Māori health providers refer their clients to the clinic. The clinic provides resources an oral health information for the Māori providers, and participates in local Māori health hui. Te Whare Kaitiaki has also focused upon the development of oranga niho promotion resources targeted at Māori and has had some success in this area. These resources will be discussed in Chapter 11. Te Whare Kaitiaki has been active in sharing these resources with other Māori health providers along with information and publications.

The one central difference between Te Whare Kaitiaki and the other two providers is that it is part of a larger mainstream organization which has the primary role of training the New Zealand dental health workforce. Therefore, another important relationship is with the students, and especially those who come from very diverse ethnic backgrounds. The reality for New Zealand today is that there is a background of political dynamics in which a very diverse and multi-cultural population is trying to come to an understanding, not only of ethnicity, race and a national identity, but also an understanding for the existence of health services that target specific ethnic groups. The Dental School is now a microcosm of ethnic diversity, not only for students but also for staff. This can give rise to a diverse range of interactions between different people of different ethnic backgrounds in clinical situations with very positive outcomes. A senior clinician described a scenario with an overseas student:

N__ was a Fijian-Indian student. It was no surprise to me that when you came back from Rotorua that year and you said that N__ was so popular with the Māori patients up there. I believe that this was because N__ was just so confident in his own culture. He could yak away for ages about his family and what they were doing. He would just come in to the clinic and he would chat away. Once he told me all about his
sister's wedding and the wedding gifts and all the gold jewellery that they have on those occasions. He was just so engaging and he was like that with his patients.

It is the nature of these relationships that a Māori provider establishes, and how those relationships are maintained, that is an underlying factor for their continued operation and success. It is these relationships that have resulted in Te Whare Kaitiaki becoming an accepted part of the fabric of the Dental School. The Dental School chose to showcase Te Whare Kaitiaki in October 1999 during a Vice-Regal visit to the Dental School by His Excellency the Governor-General of New Zealand, The Rt. Hon. Sir Michael Hardie Boys, GNZM, GCMG, QSO. The Governor-General and Lady Hardie Boys visited Te Whare Kaitiaki to see the clinic in operation and to gain an insight into Māori dental health services.

10.3.2 The commitment

That Te Whare Kaitiaki has been in operation for 15 years is testament to the commitment of those personnel involved. Having to cope with the difficulties that arose when the idea of such a service was mooted, and to cope with the manifestations of racism had not been easy. The one over-riding factor is the kaupapa of oranga niho or oral health for Māori. That it is possible to help make a difference provides the incentive to carry on.

10.3.3 The future of Te Whare Kaitiaki

The future development of Te Whare Kaitiaki and the building of both capacity and capability has to be explored. The primary outcome has been the provision of a dental service for Māori and the promotion of oranga niho to Māori. The secondary outcome has been the exposure of Māori health services and kaupapa Māori concepts to succeeding generations of dental students. A senior clinician stated:
Te Whare Kaitiaki is very valuable in being there for our students. In terms of promoting a dental service for Māori, I am not sure if the Dental School is the best place to do that. There are lots of side issues as to what is going on. To the students you are creating an awareness to what is going on with Māori health issues. If the School was to develop the clinical services further that would involve a much wider structure and organization. It would involve turning the present system around. It should be a Māori oral health service which the students attend, but at the moment it is the other way around; it is a teaching programme whereby the service is provided for Māori.

This final comment (underlined) sums up the essence of a Māori dental health service within a larger mainstream organization such as the Dental School. This comment also epitomises the difference between a mainstream dental health service and an iwi or community-based Māori dental service. This paves the way for an interesting and challenging future for the provision of Māori dental health services by the University of Otago Dental School.
Chapter 11

Whakawhanaungatanga

(Relationships)

11.1 Te Kōrero Tuatahi (Introduction)

Whānau (or family) is the basic social unit of Māori society. However, the term whānau can refer to different social groupings depending on the context in which the concept is used. Not only can whānau refer to an individual’s immediate family, it can also refer to the extended family which may include a number of generations (grandchildren, children, parents and grandparents) and wider associations (siblings, aunts, uncles, cousins). Metge has described a contemporary understanding of whānau as “a kin-cluster, a group of kinsmen who regularly co-operate for common ends” (Metge 1990). She also stated that another modern interpretation of whānau “could only be described as an elastic band. Māori who would normally restrict application of the word to quite a small group, stretch it elastically on occasion.” Metge has highlighted “an amazingly rapid expansion in the metaphorical use of whānau, to refer to groupings of people who are not connected by kinship, let alone descent,” which are “radically new usages.”

Durie states that the “processes that underpin whānau interaction constitute whanaungatanga” (Durie 2001). Whanaungatanga has been described as kinship ties which provides a sense of belonging, identification and collective strength (Ngata and Dyall 1984). Whanaungatanga is based on ancestral, historical, traditional and spiritual ties (Pere 1991). Mead states that “one component of the values associated with tikanga is whanaungatanga. Whanaungatanga embraces whakapapa and focuses upon relationships” (Mead 2003).
With the modern usage of the term whānau has come a modern usage of the term whanaungatanga. It is a term that is used to describe the interactions between different groupings, entities or agencies. In this context, the Māori Health Commission (1999) described whanaungatanga as “enabling culturally appropriate forms of relationship management and associations to be fostered and sustained.” Within the health sector, whanaungatanga is concerned with the relationships between its different component organisational infrastructures, including government, the funder, the provider and communities. Whakawhanaungatanga is to have, to develop, and to maintain interactions and relationships.

11.2 Whakawhanaungatanga Within The Health Sector

The establishment of the District Health Boards was part of the 1999 Labour Government’s restructuring of the health sector to re-establish local governance and accountability through boards responsible for the provision of health services in initially, 22 designated areas throughout the country. The Minister of Health required that the formation of the District Health Boards was to be “planned, staged and managed” (Gauld 2001). One core activity of the District Health Boards was to establish partnerships with Māori. There was a concern that, during the transition phase to the new structure, there was a risk of failure to achieve Māori partnership and participation. However, the District Health Boards established Māori health committees, and partnerships were established with iwi. Eventually, Memorandum of Understanding were signed between District Health Boards and local iwi within each Board’s area.

The Memorandum of Understanding (2003) signed between the Otago District Health Board and the four local Ngāi Tahu rūnaka on 13 February 2003 focused in the main on their relationships. Firstly, the “Treaty Relationship Agreement” between the
previous Health Funding Authority and Ngāi Tahu Development Corporation was to be upheld; secondly, the four combined rūnaka would “ensure the relationship between manawhenua (local Ngāi Tahu) and mātaawaka (other Māori) is maintained to address the needs of all Māori in the region; thirdly, both parties agreed to their commitment “to working together in good faith...” ; and fourthly, the combined rūnaka would have “effective working relationships” with the various components of the Māori community within the Board’s area. The word “relationship” appears nine times in the document, which exemplifies the importance of whakawhānaungatanga in this context.

The qualitative data in this chapter were the result of interviews with key individuals who work within the Ministry of Health and have a particular responsibility for publicly funded oral health services and the development of appropriate policy.

11.3 Whakawhānaungatanga In The Development Of Oranga Niho Services

Relationships between Māori and the health sector have been a necessary and ongoing activity in the development of Māori dental health services since 1990. TABLE 11.1 provides a list of the health sector agencies and corresponding Māori agencies that have engaged in dialogue and established relationships for the improvement of Māori oral health.
**TABLE 11.1: Health sector agencies and Māori agencies**

<table>
<thead>
<tr>
<th>HEALTH SECTOR AGENCY</th>
<th>MĀORI AGENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minister of Health</td>
<td>Minister of Māori Affairs</td>
</tr>
<tr>
<td>Ministry of Health</td>
<td>Te Puni Kōkiri</td>
</tr>
<tr>
<td>District Health Boards</td>
<td>Whānau, hapū, iwi / Māori</td>
</tr>
<tr>
<td>Primary Health Organizations</td>
<td>Iwi Trust Boards, Rūnanga</td>
</tr>
<tr>
<td>Dental practitioners</td>
<td>Māori Primary Health Organizations</td>
</tr>
<tr>
<td>Hospital dental services</td>
<td>Māori health professionals</td>
</tr>
<tr>
<td>School Dental Service</td>
<td>Māori health services (mainstream)</td>
</tr>
<tr>
<td>Dental Council of New Zealand</td>
<td>Māori health providers</td>
</tr>
<tr>
<td>New Zealand Dental Association</td>
<td>Māori health collectives</td>
</tr>
<tr>
<td>Oral Health Advisory Group</td>
<td>Te Ao Mārama, NZ Māori Dental Association</td>
</tr>
<tr>
<td>University of Otago Dental School</td>
<td>National, regional, local Māori organizations,</td>
</tr>
<tr>
<td>Health Research Council of New Zealand</td>
<td>Māori Womens’ Welfare League,</td>
</tr>
<tr>
<td>Royal New Zealand Dental Corps</td>
<td>Womens’ Health League</td>
</tr>
</tbody>
</table>

There has been interaction between almost all possible permutations of both sides, in an effort to provide information, seek clarification, submit proposals, make submissions, gain support, access funding, negotiate contracts and utilise services, or to sign memoranda of understanding, all with the ultimate aim of improving Māori oral health status. The one key relationship at the present time is between District Health Boards and Māori providers. On the one hand, the District Health Boards are required to purchase health services, as outlined in the New Zealand Health Strategy that meet both the identified population health objectives and the Māori health gain priority objectives; on the other, Māori providers have the drive, energy and a growing...
capability to deliver specific health services. In order for an effective interaction to occur between the two sides, a Ministry of Health official commented that:

The District Health Boards and the Māori providers have to determine what the relationships are with each other and have a willingness to try to work together.

In order therefore, for a District Health Board and a Māori provider to work together, the Treaty of Waitangi provides a framework which enables a meaningful working relationship to be established between the respective parties. The application of the Treaty principles of partnership, participation and protection is the basis for building Māori capability and capacity for health service provision. However, whilst this approach is admirable, there must be a willingness on the part of the Treaty partners to engage in this process. A Ministry of Health official stated that this is not always the case, with a subsequent lack of any progress or development:

A big problem is the migrant population. In Howick for example there is a huge Chinese migrant population. However the District Health Boards still have a responsibility as partners under the Treaty of Waitangi to meet the needs of the indigenous population. Don’t we have to get that one right first? That is the Treaty argument that is being made in the larger District Health Boards, but the funding is not following on. Relationships are not being established.

There is also the risk of political influence being brought to bear to undermine the progress that has been made in the establishment of relationships and hinder development. A Ministry of Health official was only too aware of the machinations of central government and politicians:
The current change in political rhetoric is about vote catching. Rodney Hide said there are MPs and taxpayers who are supporting non-profit organizations to advocate for smoking reduction through political offices. That is about paying people to change political policy through advocating with the Ministry of Health. So you get political pressure within the Ministry structure on policy.

In the political climate since the Leader of the Opposition, Dr Don Brash, gave his widely reported “Ōrewa Speech” (Brash 2004) in January 2004 (in which he called for public funding to be based on “need” rather than “race”), it may become even more difficult for District Health Boards to be responsive in meeting the dental health needs of Māori. Although there is no doubt that there is a need for appropriate dental services for Māori, there is also a requirement in the first place, for appropriate and effective relationships to be established for this to progress. A Ministry of Health official noted the problems that can occur:

There are relationship barriers. The links in the chain are the District Health Board, the School Dental Service, the Māori provider and the client group. There needs to be good relationships between the links.

The establishment of relationships between District Health Boards and Māori providers is imperative if the development of effective and appropriate intervention strategies for the reduction in the inequalities in oral health status between Māori and non-Māori is to occur. A Ministry of Health view is that there is considerably more that District Health Boards could do in this regard:

The District Health Boards may be a barrier to effective services because of reflecting differences between mainstream and some
kaupapa Māori programmes; some District Health Boards are so limited in their response to Māori oral health need that what they actually do is merely tokenism.

Each District Health Board is an autonomous body in its own right but they also have a relationship with each other through the organization District Health Boards New Zealand (DHBNZ). This body has the authority to advocate on behalf of the District Health Boards with the Ministry of Health. However, the relationships between some District Health Boards may impose barriers for Māori providers that are beyond their control to do anything about. This merely adds to the difficulties that Māori providers face in their attempts to establish working relationships with the funders. A Ministry of Health official gave an example of the difficulties that can arise:

In Auckland for example there are three District Health Boards: Waitāmatā, Auckland and Counties-Manukau. The lead agency for oral health is Waitāmatā. There is tension between them as Counties-Manukau, who not only want to get on and do their job, but also want to provide more ethnic based services and initiatives, find that their funding from the lead agency will not allow them to do that. I do not believe it to be institutionalised racism because assimilation threads through the sector. They are providing a mainstream service but there is little or no recognition that they are meeting the needs of the whole community.

The argument that there is inadequate government funding for the District Health Boards to purchase health services that meet the needs of the whole population, and that prioritisation of funding has to be undertaken by the District Health Boards as a matter of course, only results in putting relationships with Māori at some risk. Whilst
the formation of a relationship between a District Health Board and Māori may be amicable at the governance level through the signing of a memorandum of understanding. The relationship at the operational level may be somewhat tenuous. A Ministry of Health official who was in a position to gauge the District Health Boards’ responsiveness to Māori across the country noted that:

**The development of that relationship depends on how the District Health Board prioritises things. Unless there was a person within the District Health Board that was fully committed to maintaining good relationships with the Māori provider, or with supporting and advancing the kaupapa, then things won’t happen.**

**I have noticed a difference between various District Health Boards. Some District Health Boards say things like, “What problem? We don’t have a problem in our area”, or, “What Māori thing?” The thing is, they do not recognise that there is a problem with oral health for Māori.**

On one side, the funder has been constrained by government policy and service specifications whilst on the other, Māori only wish to provide the best possible service for their community. There can be a real divide between the two sides:

**The work of Māori providers is not always recognised by the funder.**

**The Māori community identifies the need, but is there a recognition of that need by the District Health Board?**

**They don’t link the need, with the requirement to meet that need.**
The nature of the divide that exists between Māori and a District Health Board’s manager of dental services has been described as a difference in the perception that each has of the other. This situation became very evident to a Ministry of Health official:

*Within the District Health Boards and the School Dental Service there is little understanding of what it means to work with whānau.*
*On the other side, there is the perception on the part of Māori of the School Dental Service, which is that they are “that Pākehā service”.*

There is consequently a need to develop the processes of *whakawhanaungatanga* between the District Health Boards and Māori providers which are effective and meaningful in an effort to overcome the misconceptions that have arisen. There are however, a number of relationships that Māori providers have established and maintained in an effort to ensure that they can provide the best possible service to their essentially Māori client base.

### 11.4 Whakawhanaungatanga and Māori Oral Health Service Providers

At the level of oral health service delivery, Māori providers have developed and maintained extensive relationships which enhance their health service profile, contributing to their credibility, accountability and acceptance by the client group. Tipu Ora Dental Service, Te Ātiawa Dental Service and Te Whare Kaitiaki have established key relationships which have resulted in a variety of outcomes:

Tipu Ora has (or has had) relationships with:

- The Minister of Health who ensured that initial funding was provided;
- Lakeland Health District Health Board for contract negotiation;
Tipu Ora have established and maintained extensive networks and relationships prompting a Ministry of Health official to state:

*Tipu Ora have very good relationships; they will talk to mainstream.*

Te Ātiawa Dental Service has (or has had) relationships with:

- Local Members of Parliament and the Associate Minister of Health seeking support for funding;
- The Taranaki District Health Board with submissions and proposals for funding;
- Local dental practitioners through their own dentist for support and surplus equipment;
- Taranaki Base Hospital Dental Service for the mutual referral of patients;
• The School Dental Service for some shared services and co-operation;
• The Dental Council of New Zealand for registration of dental personnel;
• The New Zealand Dental Association membership of dental personnel and presentations on Māori health services to the Taranaki Branch;
• The Oral Health Advisory Group membership; and
• University of Otago Dental School for oral health promotion resources.

Te Whare Kaitiaki has (or has had) relationships with:
• Minister of Health (King 2000) who recognised the importance of oranga niho services and this one in particular;
• Ministry of Health (Te Kete Hauora: Māori Health Directorate) to provide information on oranga niho services and the developing Māori dental health workforce;
• Otago District Health Board for contract funding and the previous Southern Regional Health Authority for funding for oranga niho promotion resources;
• University of Otago Dental School staff for patient referral, advice, guidance, support and information;
• School Dental Service for the treatment of the children of Te Kura Kaupapa Māori O Ōtepoti and the development of oranga niho resources.
• Dental Council of New Zealand for registration of dental personnel;
• New Zealand Dental Association membership of dental personnel; and to provide advice and information
• Oral Health Advisory Group membership; and
• The Royal New Zealand Dental Corps for Māori community civilian dental projects.

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The outcome of these relationships has resulted in a wide variety of positive outcomes, including: Te Ātiawa Dental Service taking the lead in community based oral health promotion activities in New Plymouth; Tipu Ora providing active support for the Rotorua campaign for the introduction of fluoridation; the Dental Council of New Zealand requesting Te Whare Kaitiaki assist in the development of a code of cultural practice for the dental profession; the development of unique oranga niho promotion resources targeted at Māori; the dissemination of oral health information to the Māori community; and the establishment of models of Māori dental health service that have been of assistance to other īwi groups and Māori providers.

Not only have relationships between the health sector and Māori been established, there are also important relationships both within the health sector and within Māoridom with respect to oranga niho services. Firstly, within the health sector the outcome of intra-sector relationships resulted in the identification of both Māori health and oral health as a population health priority. Māori oral health was also identified as a Māori health gain priority area. Secondly, within Māoridom there has been an extensive network built up between Māori providers, īwi authorities and Māori within government agencies for the sharing of information, resources and strategies. It is these latter relationships that have seen the number of Māori providers with District Health Board contracts for oral health services grow to 15 by 2004. The main outcome of relationships between the health sector and the Māori dental health sector has resulted in a review of Māori child oral health services being undertaken in 2004. The success of such a review will depend on the establishment and maintenance of an effective working relationship between the Ministry of Health and the Māori dental health providers.
The need for the establishment and maintenance of effective working relationships between Māori and all levels of the health sector (including the dental health sector) is absolutely essential if the current government policy of reducing inequalities in health status (including oral health status) is to be implemented. The diverse nature of relationships between District Health Boards (including their dental health service contract management) and Māori (including health providers and iwi authorities) has been identified. Although some relationships between some District Health Boards and Māori have been meaningful, helpful and very positive, other such relationships have been non-existent, or tenuous and fraught with frustration. A Ministry of Health official commended the positive outcome of whakawhanaungatanga:

*Our understanding of the dental health services provided by Tipu Ora Dental Service, Te Ātiawa Dental Service and Te Whare Kaitiaki has revealed the excellent relationships that they have established with all the stakeholders in their respective communities. The basis of the relationships that they each established was built on mutual respect and understanding with the common aim of providing the best possible service to meet the dental health needs of their client group.*

The establishment and maintenance of effective working relationships occurs against a background political influence. The health sector is sometimes required to react and respond to a changing and often volatile political climate. As a response to the Ōrewa speech by Dr Don Brash, the government established a race relations minister who was tasked with reviewing ethnically-targeted government programmes (*Otago Daily Times* 2004a). The current review involves an examination of 23 programmes “in what is considered a representative sample of similar policies in a range of
government departments.” Whether or not Māori oral health services are included in the 23 programmes under review is not known at the present time, and the outcome will not be known until the end of the year. This has the potential to put Māori oral health services at some risk. Whatever the case, the maintenance of effective relationships between Māori and the dental health sector is important now, as never before.
Chapter 12

Māramatanga

(Enlightenment)

12.1 Te Kōrero Tuatahi (Introduction)

Māramatanga can be translated to mean enlightenment, a concept about coming to, or arriving at, an understanding of knowledge. Embodied within Māramatanga is the expectation of a potential betterment through the subsequent application of that knowledge. The cosmology of te ao Māori (the Māori world) relates how out of the darkness there came light, and in the light, the world as we know it today was created. Shirres states that “the whole universe comes from that point, i te kore ki te pō ki te ao mārama, ‘from the nothingness to the night, to the world of light’ (Shirres 1997). One version of the creation story, Te Tīmatanga (The Beginning) was composed by J Broughton with a Māori translation by kaumātua, Mr Karaka Roberts (Cited in Rimene et al. 1998).

Mai i te tīmatanga ko te kore
Ka puta ki waho te kore tino nui
Te Pō
Te Pō Roa
Te Pō Nui
Ka puta ki waho ko Te Ata.

In the beginning there was Te Kore.
The Nothingness.
Out of this Great Nothingness came
Te Pō, the Night,
Te Pō Roa, the long Night,
Te Pō Nui, the Great Night.
Eventually came Te Ata, The Dawn.

Taukuri e! Ko Rangi-nui
Taukuri e! Ko Papa-ū-ū-nuku.
E awhi ana ia rua.

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Behold! There was Rangi-nui, The Sky Father
With his beloved Papa-tū-ā-nuku, The Earth Mother,
Cradled in each others arms.

*Tāne-mahuta, tetāi o ngā tama,
I wehe ōna mātua.
Rangi-nui ki runga,
Papa-tū-ā-nuku ki raro.*

One of their children, Tāne-mahuta,
Forced them far apart,
The Sky Father above,
The Earth Mother below.

*Ka tangi tonu a Rangi-nui mo Papa-tū-ā-nuku
Mai i te wehenga tae mai ki tēnei rā.*

Rangi-nui wept bitterly for his beloved
And his tears are the rain that falls to this very day.

*Ka kākahutia e Tāne a Papa-tū-ā-nuku ki ngā korowai o ana tamariki.
Ngā manu me ngā ngāngara o te whenua.
Tāne ki a Rangi-nui ko te korowai o ngā whetū o Te Ao Tūroa.
Ngā taonga a Tāne ki ōna mātua
Ko te Rā me te Marama.*

Tāne clothed Papa-tū-ā-nuku in the plants, the trees, the forests.
He gave the birds of the air and the insects of the earth.
He gave Rangi-nui a beautiful cloak of stars.
The sun and the moon were gifts for his parents.

*Ko Tāne-mahuta te Atua o Te Ngahere.
I kokiri te māramatanga me te mātāuranga ki Te Ao Tūroa
Māramatanga me te mātāuranga,
Te Pō me Te Ao Mārama.*

And so it was that Tāne Mahuta, God of the Forest
brought Light and Knowledge into the world.
Light and Knowledge.
Night and Day.

*Tīhei mauri ora!*

Behold, the breath of life!
As the Universe was created, the divisions of darkness and light eventuated, culminating in the cycle of night and day. With the light of day there was knowledge, understanding and enlightenment. Mead translates māramatanga as “enlightenment” and te māramatanga as a “research principle of expanding knowledge towards light” (Mead 2003). The modern usage of the term would encompass the notions of mātauranga (education) and mohiotanga (knowledge and understanding). Hence, within the context of health and well-being, health promotion can be regarded as an activity that brings about enlightenment or māramatanga.

12.2 Health Promotion

The World Health Organization (W. H. O. 1986) described health promotion as:

... the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health. Health promotion represents a mediating strategy between people and their environment, combining personal choice and social responsibility for health to create a healthier future.

A number of models of health promotion have been developed. Brown and Treasure stated that “the development of the “new public health” has led to a revolution in the way in which health promotion should be approached”. This was “crystallised” in the 1986 Ottawa Charter for Health Promotion (Brown and Treasure 1992). Ten years later, in 1997, the Jakarta Declaration On Health Promotion (1997) formulated an approach to health promotion for the 21st Century. A third model of health promotion was developed by Māori in 1999, called Te Pae Māhutonga (Durie 1999). Whilst the first two models can be readily applied to Māori oral health promotion, it is Te Pae Māhutonga that has been developed by Māori, for Māori, utilising a kaupapa Māori framework.
12.2.1 The Ottawa Charter

The Ottawa Charter for Health Promotion (1986) was the outcome of the first International Conference on Health Promotion, held in Ottawa in November 1986. The Charter defined health promotion as “the process of enabling people to increase control over, and to improve, their health”. The Charter acknowledged the prerequisites for health (peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity) as being necessary for an improvement in health. The means to health promotion action were identified with five principles: build health public policy; create supportive environments; strengthen community action; develop personal skills; and reorientate health services.

The New Zealand Health Strategy Oral Health Toolkit, Improve Oral Health recognised the Ottawa Charter as being the “best available approach for co-ordinated health promotion and the elimination of ill-health among New Zealanders” (Ministry of Health 2004b). The Toolkit includes a section on the School Dental Service Guidelines for Oral Health Promotion based on the five principles of the Ottawa Charter. However, the Toolkit makes the point that “recent research suggests that the traditional health education approach is both ineffective and inefficient. Health education interventions without the broader support of appropriate oral health promotion measures are likely to fail.” This cautionary note would support the notion that oral health promotion targeted at Māori should, in the very least, be culturally appropriate, meaningful and acceptable. The relevance of Te Pae Māhutonga is therefore, very significant.

The principles of the Ottawa Charter can be applied to Māori oral health promotion:

i. Build healthy public policy
   • The New Zealand Health Strategy is based on seven principles, the first one of which acknowledges the special relationship between Māori and the Crown under the Treaty of Waitangi (King 2000a);
• A goal of *The New Zealand Health Strategy* is to reduce inequalities in health status, particularly for people from lower socio-economic groups, Māori and Pacific peoples; and
• *The New Zealand Health Strategy* includes the improvement of oral health as a priority population health objective.

ii. Create supportive environments
• *He Korowai Oranga, The Maori Health Strategy* focuses upon *whānau ora*, the health of the family, as its prime objective.

iii. Strengthen community action
• Māori community ownership of oral health services and oral health promotion activities through the development of community or *iwi*-based Māori health service provision.

iv. Develop personal skills
• The development of appropriate information resources that lead to healthy lifestyle changes and behaviours.

v. Reorientate health services
• The development of a Māori dental health workforce; and
• The placement of school dental therapists with Māori providers rather than being school based.

An application of the Ottawa Charter for Māori health promotion is *TUHA-NZ* which is “an understanding about the application of the Treaty of Waitangi in health promotion practice in New Zealand” (Health Promotion Forum of New Zealand 2002). The document provides a means for action that was developed over several years by the Health Promotion Forum of
New Zealand and published in 2002. It is based on the Ottawa Charter, and provides a process for health promotion that uses the three Articles of the Treaty of Waitangi as a framework. The goals of TUHA-NZ are:

- **Goal One:** Achieve Māori participation in all aspects of health promotion.
- **Goal Two:** Achieve the advancement of Māori aspirations.
- **Goal Three:** Undertake health promotion action which improves Māori health outcomes.

These goals can also be regarded as an application of the three widely recognised principles of the Treaty of Waitangi; participation, partnership and protection. TUHA-NZ is very useful in that it articulates a process by which the Ottawa Charter can be applied and implemented for New Zealand.

### 12.2.2 The Jakarta Declaration

The Fourth International Conference on Health Promotion, held in Jakarta in July 1997 resulted in a *Declaration On Action For Health Promotion into the 21st Century* based on five priorities (W.H. O. 1997). These priorities can be applied to Māori oral health promotion:

1. **i. Promote social responsibility for health**
   
   Oral health is just one part of overall health and well-being. The health of the *whānau* is just as important as the health of the individual and the health of the oral cavity. This is the focus of *He Korowai Oranga, The Maori Health Strategy*, which has an emphasis on the health and responsibility of *whānau* rather than the individual.

2. **ii. Increase investments for health development**
   
   The funding agencies (the District Health Boards) must make adequate funding available for the purchase of appropriate and effective oral health services for Māori in order to build Māori capacity and capability.
iii. Consolidate and expand partnerships for health

Māori providers have engaged in partnerships within the New Zealand dental health sector for the development of oral health promotion resources. Māori recognise the sharing of information, ideas and resources as a very important strategy for effective health promotion.

iv. Increase community capacity and empower the individual

Māori health providers that are community or iwi-based provide a sense of community ownership for their essentially Māori client group. This has the potential for positive health outcomes.

v. Secure an infrastructure for health promotion

The structure of Māori society is based on whānau, hapū and iwi. This social organization is a basic tenet of Māoridom and is a powerful tool for the provision of services and the implementation of oral health promotion.

12.2.3 Te Pae Māhutonga

Durie has brought together the elements of modern health promotion in a cohesive manner based on Te Pae Māhutonga, the Southern Cross constellation of stars (Durie 1999). He states (Durie 2003):

Te Pae Māhutonga has long been used as a navigational aid and was closely associated with the discovery of Aotearoa and then, some centuries later, the rediscovery of New Zealand by European voyagers. The constellation has four central stars arranged in the form of a cross, and there are two stars arranged in a straight line that point towards the cross. They are known as the Pointers. Because it is an icon of New Zealand, and because Te Pae Māhutonga has served as a guide for successive generations, it can be used as a symbolic map for bringing together the significant components of health promotion...."
The four central stars can be used to represent the four key tasks of health promotion and can be named accordingly to reflect particular goals of health promotion: Mauriora, Waiora, Toiora and Te Oranga. The Pointers are Ngā Manukura and Te Mana Whakahaere.

Brown and Treasure made the point that “although people may have knowledge which would give them better health, it may not be possible for them to use that knowledge because of economic constraints, the pressures of advertising, and cultural barriers” (Brown and Treasure 1992). The emergence of Te Pae Māhutonga is therefore of considerable importance, as it embodies the very essence of tikanga Māori (Māori cultural beliefs and practices). It provides a context for Māori that makes the access and application of knowledge culturally relevant and meaningful. Perceived barriers may no longer exist. Not only is the way forward very clear, the pathway is well lit. Te Pae Māhutonga is an example of māramatanga. Although Te Pae Māhutonga is based on cultural constructs from te ao Māori (the old world of the Māori), its application today is to provide for health and well-being for tomorrow. The principles of Te Pae Māhutonga are: Mauriora (access to Te Ao Māori); Waiora (environmental protection); Toiora (healthy lifestyles); Te Oranga (participation in society); Ngā Manukura (leadership); and Te Mana Whakahaere (autonomy).

12.2.3.1 Mauriora (Access to Te Ao Māori)

The basic foundation of mauriora is to have a secure cultural identity. Cultural identity was described in Chapter 5 as being an important component of te taha hinengro, the mental dimension of Te Whare Tapa Whā (the Māori model of health and well being). Durie states that “a task for health promotion is to facilitate access to te ao Māori” which would include language, culture, institutions (such as the marae) and Māori networks (such as whānau, hapū and iwi), (Durie 2003). Māori cultural constructs can be applied to Māori oral health education to deliver a particular oral health message. The intention is that the message being conveyed is instantly recognisable by the Māori target group and is consequently more
meaningful and appropriate. As a result, positive lifestyle changes can be implemented for the improvement and maintenance of oral health.

An example is *Te Kete Oranga Niho*, which is a woven flax basket based on the three baskets of knowledge that, according to Māori mythology, Tāne-mahuta (God of the Forest) ascended into the heavens to bring back for the enlightenment of humankind. The *kete* used in this oral health promotion resource contains a number of Māori oral health education information pamphlets and resources, including a toothbrush and tube of toothpaste. This resource is further described in the Appendix.

12.2.3.2 Waiora (Environmental protection)

Durie makes the distinction between *mauriora* (which is associated with inner strength and a secure cultural identity) and *waiora* (which is associated with the external world and “a spiritual world that connects human wellness with cosmic, terrestrial and water environments”). The key aspect of *waiora* is that “health promotion must take into account the nature and quality of the interaction between people and the surrounding environment.” The interaction between Māori and the environment in the context of oral health is concerned with water, and the fluoridation of water supplies.

The fluoridation of water supplies is a highly effective public health measure that protects the oral health of populations by reducing the prevalence of dental decay. The fluoride ion in the water exerts its effect by acting on the enamel surface of the tooth (Thomson 2000). The fluoride ion in the water works to reverse the very early carious lesions in the dental enamel by: firstly, reducing demineralisation; and secondly, by promoting remineralization. Fluoride also acts on the plaque biofilm to change its composition and reduce acid production.

In New Zealand, water fluoridation is particularly beneficial for children, Māori and disadvantaged people (Ministry of Health 2004a). There have been numerous reports
(Colquhoun 1977, Hunter 1984, de Liefde 1998, Wright et al. 1999, and Lee and Dennison 2004, among others) which have clearly demonstrated the beneficial effects of fluoridation in New Zealand, particularly for those “at-risk” groups including Māori. Thomson et al. (2003) reported on data from the School Dental Service which “suggested that ethnic inequalities in child oral health status are more pronounced in areas that do not receive optimally fluoridated water.” This was confirmed by Lee and Dennison (2004), who reported that “children living in a fluoridated area have significantly better oral health compared to those not in a fluoridated area. These differences are greater for Māori and Pacific children and children of low socio-economic status.”

There have been a number of efforts in recent years by particular Māori communities and organizations to support the fluoridation of their water supplies, including Whangārei, Wairoa and Rotorua¹. In each case, the local authorities voted in the end not to introduce water fluoridation, despite the high Māori population and the high rates of dental caries in children and young people in these areas. In Te Tai Tokerau (Northland), the Māori health providers with the support of the Ministry of Health, published a 16-page booklet in 2002, “Water Fluoridation, Te Whakapū Kowhai Wai” to promote the fluoridation of water supplies. The key statement in their campaign was the whakatauki (proverbial saying) Te whakaora tohu i ngā niho o ō tātou whānau (Helping keep the teeth of our whānau healthy). This was a community initiative which involved many people across the dental health sector including the Ministry of Health and Māori dental health providers. The booklet was published in both te reo Māori and English, and began by placing the importance of healthy teeth in the cultural framework of te ao tawhito (the old world of the Māori). This was an example of Māori oral promotion using the environment te moana, (the sea), and ngā ngahere, (the forests), as a basic foundation of health. This resource is further described in the Appendix.

12.2.3.3. Toiora (Healthy lifestyles)

Lifestyle factors (alcohol, smoking, diet, drug and solvent abuse, and gambling) impact negatively on individuals, communities and populations. The unfortunate outcomes of these factors (illness, disability and premature death) are, in the main, preventable. Durie states that “toiora, as distinct from mauriora and waiora, depends on personal behaviour” (Durie 1999). It is a global phenomenon that poorer people have poorer health (Thomson et al. 2003). Schou states that children who are socio-economically better off have “more favourable attitudes, behaviours and oral health knowledge” than those children who are less well off (Schou et al. 1994). People who are socio-economically disadvantaged tend to have fewer choices in life and consequently, the impact of negative lifestyle factors upon them tends to be more severe. Durie makes the point that the “risks are highest where poverty is greatest” (Durie 1999). Health education is therefore partly concerned with providing relevant and appropriate information that allows the individual to make a choice to change from potentially harmful behavioural practices to healthy behavioural practices. What is even more important is the impact that health promotion may have on the social environment in which people live and thereby making it easier for them to make healthier lifestyle choices. For Māori and oranga niho, both diet and oral hygiene are the important issues.

The impact of an unhealthy diet has had a negative outcome for Māori. The 1997 New Zealand Nutrition Survey reported that 57 per cent of Māori men and 61 per cent of Māori women were overweight, compared to 54 percent of European men and 47 per cent of European women (Te Puni Kōkiri 2000). Rates were greater in older age groups with 81 per cent of Māori men aged 45 years and over, and 78 percent of Māori women in this age group, being obese or overweight. The 1996/97 New Zealand Health Survey reported that 16 per cent of Māori in the 45-64 age group had been diagnosed with diabetes. This was four times the rate for New Zealand non-Māori in the same age group (Cited in Te Puni Kōkiri 2000).
In the modern consumer age, fast foods and carbonated soft drinks have become a normalised part of the social fabric of society. Coca Cola is the biggest selling supermarket item in New Zealand (Wakelin 1996). It is also cheaper to buy than fresh milk. Moreover, Māori are high consumers of fast foods. In South Auckland, 10,000 children visit McDonalds every week (Johns 2000). A Radio New Zealand *Insight* documentary on the dental health of Northland children (broadcast on 3 December 2000) identified high-sugar diets as a major factor in the unacceptably high caries prevalence in the children (National Radio 2000). A Māori health community worker interviewed for the programme said:

The children are fed shocking diets: lots of lollies, carbonated soft drinks.

Coke is cheaper than milk.

Many of the children do not have regular meals; they are given lollies and rubbish-type food.

In that programme, Dr Callum Durward (Paediatric Dentist at Green Lane Hospital) stated:

Many young mothers are from under-privileged homes and are never taught the link between a high sugar diet and tooth decay. If child goes to bed on a regular basis with a bottle of juice, milo or milk, then acid forms and stays on the teeth all night resulting in decay. When this happens at the age of 1 or 2, the children are often too young to treat in the dental chair. Only water is safe to have in a bottle at night. Children should drink more water and milk and less soft drinks and juice.

A sugar-containing diet is a major cause of dental decay, especially for children, teenagers and young adults. In the immediate post-war era of the 1950s and 1960s, carbonated soft drinks were generally only consumed at special occasions such as weddings, birthdays and Christmas. Today, with mass marketing by multi-national companies it appears to be a daily occurrence. A Māori health community worker interviewed for the Radio New Zealand *Insight* documentary said:
Parents and families just do not seem to be getting the message that you just can’t graze all day on sweet sugary food.

Oral health promotion becomes very difficult against this background of consumerism and aggressive marketing by multi-national corporations. A response to these pressures has been an increasing tendency to seek legal redress from the manufacturers, distributors or marketers of particular products, by those who have become adversely affected through excess consumption of those products. In New Zealand, as in the USA, there have been attempts to sue the tobacco companies by those who have suffered from severe ill-health as the result of cigarette smoking, for not making them aware of the harmful effects of smoking (Sunday Star Times 2002). In September 2004, the US Government filed a $NZ427 billion action against the top tobacco companies in the United States for “colluding for decades to hide evidence of the health hazards of smoking” (Otago Daily Times 2004b). Recent moves have also been made in the United States to ban lawsuits against fast-food chains by those who have become obese as a result of over-indulging in the consumption of their products (CBS News 2004). The Personal Responsibility in Food Consumption Act, nicknamed the ‘Cheeseburger Bill’, protects food manufacturers, distributors, sellers, grocery stores and all restaurants from litigation (Washington Times 2004). It would not now be possible for the judiciary to accept a writ for damages against a soft drink or confectionery manufacturer in relation to the development of caries in an individual (such a writ could not be proved in any case because of other mitigating factors such as oral hygiene care and fluoridation). Thus, there comes a point where personal health is a matter of personal responsibility. Parents and caregivers must also be responsible for the health of their children. A member of the Tipu Ora Trust who was interviewed for this thesis stated:

_A lot of mothers didn’t understand the effect of diet because of their own oral health. Our kaitiaki give education about a healthy diet. No sugar in milk drinks and no fizzy drinks._
We promoted good dental health. I can say from personal experience that, what you eat, is what you get, is what you are.

In Britain, confectionery manufacturers are to cease production of “some of their ‘king-size’ chocolate bars in a bid to tackle obesity. The reduction of portion sizes is one of the seven pledges in the first Manifesto for Food and Health published by the Food and Drink Federation” (BBC News 2004). The response by the leading British food manufacturers to growing pressure “about portion distortion and rising levels of obesity” was to reduce oversize snacks (some weighing as much as 100 grams and containing 387 calories) down to “two shareable portions” (CNN, 2004). Whilst obesity has become a major health concern for young people in the Western World, there has not been the same response to oral health and caries as outcomes of high sugar diets as there has been to obesity. The 2002 National Children’s Nutrition Survey reported that 41 per cent of Māori children were either overweight or obese, and this was a particular concern among girls (47 per cent), (Ministry of Health 2003). The Survey also reported that “Māori children had high usual intakes of sugar and fat.” These are very significant findings and the contributing factors are varied and complex, making the solutions equally varied and complex. This is one of the many challenges facing Māori and oral health promotion today.

Oral health care behaviour includes not only attention to diet and the intake of high sugar containing foods, but also oral hygiene practices of plaque control and tooth brushing. The Radio New Zealand Insight documentary also focussed upon this aspect of poor oral health. A school dental therapist interviewed for this programme said:

The children do not brush their teeth. Often, there are no tooth brushes in the homes.
The 2002 National Children’s Nutrition Survey also reported that “over one fifth of Māori children (28 per cent of boys and 21 per cent of girls) did not report brushing their teeth the previous day.”

Oral hygiene practices for the control of plaque will lead to a healthy mouth and a reduction in caries. It is just as important as reducing sugar intake in the diet. These are the critical messages in oral health education that depend on personal behaviour for a healthy outcome. Māori health providers are all too aware of this and efforts have been made to develop oral health education resources and activities targeting Māori. These include the Brush-In programmes in Northland, Oral Health days in Taranaki and the Taine Randell oranga niho education in Otago (the latter resource is described in the Appendix).

12.2.3.4 Te Oranga (Participation in Society)

Durie (2003) makes the point that well being is not only about mauriora (a secure cultural identity), waiora (an intact environment), and toiora (the avoidance of risks), it is also about “the goods and services which people can count on, and the voice they have in deciding the way in which those goods and services are made available.” For this to occur, “well-being, te oranga, is dependent upon the terms in which people participate in society and the confidence with which they can access good health services.” Health promotion, Durie concludes, “is about enhancing the levels of well-being by increasing the extent of Māori participation in society.”

For oral health promotion, Māori participation includes active participation in the dental health sector as facilitators, practitioners and decision makers, rather than just as patients. There has been a significant increase in the Māori dental health workforce over the last decade which has been discussed in Chapter 4. There is also a need for an increasing acceptance by mainstream providers for Māori to participate in the organizational infrastructure of the dental health sector, including the Dental Council of New Zealand, the
respective dental health sector boards, dental professional associations, Ministry of Health officials and policy analysts, and District Health Board managerial roles.

An increase in Māori participation in the dental health sector (and Māori oral health promotion, in particular) occurred through the advent of Māori dental health educators. This role came into being in 1998 following (what became referred to as) the Government’s “Decile 1” funding. Under this scheme, the Government made $1 million available per year for three years for Māori, Pacific, low-income and rurally isolated pre-school children to access dental care (Health Funding Authority 1998d). This funding was distributed throughout the country on the basis of Decile 1 schools; the more Decile 1 schools in a local authority area, the more funding would be made available to that area. Māori health providers who accessed this funding used it to appoint Māori dental health educators. These educators were to liaise between dental health services (in particular the School Dental Service) and Māori communities to provide information and oral health resources, and to promote oral health. In areas of high deprivation, these health workers have made a considerable impact.

The dental health educator in Kawakawa stated (National Radio 2000):

In the kōhanga, our children have tooth brushes. Often it is the first tooth brush that they have ever owned; it may be the only tooth brush in the house.

One of the reasons for the establishment of Māori oral health educators was the increasing workload of school dental therapists in some areas. Many were no longer able to undertake oral health education activities within schools because of the high clinical treatment needs. The kuia (respected female elder) and founder of Tipu Ora, herself a retired Māori school dental therapist, stated:

When I was a school dental therapist we did a lot of dental education and promotion with the children. We did that in the class room. There was more
dental education done then, back in the 60s. There is not as much done now as there used to be. It would be good for the dental therapists to go into the kōhanga reo to talk to them about dental health care.

Māori oral health educators have a role that was once the sole domain of the school dental therapist. They have become an accepted part of Māori health service provision alongside Māori asthma educators, Māori diabetic educators, Māori smokefree educators, and rangatahi sexual health educators. The expectation is that their participation in the dental health sector will lead to a significant increase in dental health awareness in the Māori community. The Tipu Ora Dental Service experienced an immediate improvement in the use of their service following the appointment of a Māori dental health educator (as discussed in chapter 8). Māori dental health educators featured in the review of Māori child oral health services by the Ministry of Health (Mauri Ora Associates 2004).

12.2.3.5 Ngā Manukura (Leadership)

Durie states that “leadership in health promotion should reflect a combination of skills and a range of influences.... unless there is local leadership it is unlikely that a health promotional effort will take shape or bear fruit” (Durie 1999). Since the mid 1990s, there has been a slow but steady growth of Māori leadership in oranga niho within the health sector. Not only has there been an increase in the Māori dental health workforce, there has also been a corresponding increase in Māori health providers becoming increasingly responsible for promoting, supporting and initiating Māori oral health. More often than not, Māori oral health promotion activities have not occurred in isolation, but have been developed in partnership with other agencies or organizations. One such example is the Brush-In programme in Northland.

The “Brush-In” programme was introduced in Northland in the mid-1990s by Hauora Whanui (The Māori health provider) and, by 1997 it was operating in 17 schools which were, in the
main, rural schools in non-fluoridated areas (Medvac 1997). The children were supplied with tooth brushes and toothpaste, and time was set aside after lunch every day for the children to brush their teeth. A few months after the implementation of the programme, the school dental therapist at Kawakawa reported that “the Brush-In programme is rocketing ahead. It is really doing so well that it is being extended to pre-schoolers” (Te Ao Mārama 1997c). By 2003, Hauora Whanui was funding the programme for 1500 primary school children and 17 kōhanga reo with the children being assessed every five years. The initial examination of children at Waikare Primary School (east of Kawakawa) and Ōmanaia School (near Rawene) in 2003 revealed that the permanent teeth of the participating children were caries-free (New Zealand Herald, 2003a). The programme had the full support of the school principals in the area who had noticed “a change in the children’s teeth as soon as the tooth-brushing programme began” (New Zealand Herald 2003b). Their motivation for the programme came from the effects of good health on learning and education; one principal stated that “before children can learn to read or write, they need to be healthy.” This was a local oral health promotion exercise that was introduced and maintained through the leadership exhibited in the beginning, by the local Māori provider, and supported by the local schools. For this to happen required the establishment of good working relationships and understanding between the health provider and the school.

12.2.3.6 Te Mana Whakahaere (Autonomy)

An important factor in health promotion is community ownership. Durie states that “good health cannot be prescribed” (Durie 1999). Instead, “communities must ultimately be able to demonstrate a level of autonomy and self determination in promoting their own health.” An unfortunate example where a health promotion resource was developed for Māori but was immediately rejected by the target group was the immunisation booklet developed by the New Zealand General Practitioners’ Association and the Royal New Zealand College of General Practitioners (1994). The cover of the Booklet, Immunisation; Questions and
Answers for parents and whānau was illustrated by an owl sitting on a syringe with the slogan “Be wise! Immunise”. For many Māori, the owl or morepork is the harbinger or messenger of death and the health message was therefore perceived as “if you are immunised you will die.” This was not the health message that the medical fraternity had intended to promote. This resource was developed without any communication or dialogue with the target group. After discussions with the Māori Women’s Welfare League, the resource was rewritten with new illustrations; the owl was replaced by an image of three woven flax baskets or kete, a symbol of wisdom for Māori. There was initially no consultation with Māori in the development of this resource. Consequently, Māori have become very assertive in ensuring that health promotion resources, activities and programmes have Māori autonomy from the outset. For this to occur requires Māori control, the recognition of Māori aspirations, relevant processes, sensible measures and self governance.

An example of Māori community ownership of an oral health promotion initiative was the oranga niho promotion undertaken by the community in Mangakino, a small central North Island township. The local Māori health community worker in Mangakino had been impressed with the concept of te kete oranga niho (the woven flax basket for oral health), and had decided to develop a programme for an oral health promotion day for the local pre-school children based on the concept of a kete. However, she did not want to use the kete that had already been devised and distributed in the Otago region. Instead, she wished to build on the original concept with a programme that had the full support and active participation of the local community. She commented\(^2\) that the necessary resources were already there in the local community for this project: firstly, abundant flax grew in the region; and secondly, there were many women with the skills to weave several hundred flax kete. A Community Working Group was established and, for two mornings a week for six months, the local women gathered to collect flax, to prepare it and to weave several hundred flax kete. This activity became an important social interaction for the local community. The kete were filled with

\(^2\) Personal communication, Maarama Follas, 23 February 2000.
oral health promotion resources that were developed locally together with toothbrushes and toothpaste and presented to the children during their “Mangakino Oral Health Launch Day” on 16 March 2000. The intention was to follow up the Oral Health Day with a Brush-In programme in all the participating pre-schools. This was a community project that was community owned with community autonomy, “te mana whakahaere” in action.

Similar activities have been staged by other Māori dental health providers. Te Ātiawa Dental Service organized and ran annual oranga niho promotion days for the local primary and secondary schools. They were able to draw on resources developed by other Māori dental health providers, as well as producing their own posters, flyers and pamphlets. Te Whare Kaitiaki participated in two Māori Health Expositions in Dunedin with oranga niho education booths and, on one occasion, the launch of te kete oranga niho. In each case, the Māori oral health provider had control of the education activity which ensured that Māori aspirations were upheld and the activity was presented in the most appropriate way. A measure of their acceptance can be gauged in an informal manner: firstly, from the full support for these oral health promotion activities by other Māori health providers; and secondly, from the positive responses received from the client group.

12.3 Māramatanga and oranga niho

Oral health promotion is an integral part of oral health services. Clinical services will meet the treatment needs of the patient group, but long-term maintenance of oral health requires, as well as broader health promotion support, the constant, positive and regular reinforcement of appropriate oral health messages. For Māori, it is a reasonable assumption, based on their generally poor use of regular dental care, that this has not always been the case (Broughton and Koopu 1996). Broughton stated that “it is clear that the dental health needs of the Māori people have not, and are not being met” (Broughton 1993b). One of the contributing factors
to this unacceptable situation was the complete lack of any Māori-specific oral health promotion resources and activities. A senior dental clinic administrator for Te Whare Kaitiaki recognised the need for such resources:

One thing that I have thought a lot about is that we could have more education pamphlets about dental health, especially in different languages. I have collected these items here and put them in the clinic so that they are available for you to use. I think that it is good for such things to be available in different languages. We actually need more of them.

It was not until 1990 that the first oral health education resource that targeted Māori (in particular) was produced. This was an initiative by the New Zealand Dental Association, who published a colourful pamphlet on dental health services in te reo Māori. Unfortunately, this pamphlet had a somewhat a limited lifespan and has now completely disappeared. This was followed by the *Oranga Niho Oranga Kata* (Healthy Teeth, Healthy Smile) bilingual pamphlet published by the Public Health Commission (1994a) which targeted Māori pre-school children and their whānau. This is the pamphlet referred to in the above comment from the clinical administrator for Te Whare Kaitiaki.

The lack of Māori-specific oral health education resources limits the dissemination of knowledge and information about oral health within the Māori population. This situation, combined with the socio-economic determinants of health, can lead to a less than desirable response to oral health care, especially in young people. A senior clinician at the University of Otago Dental School commented:

*In the post-Dental Benefit age, that is after the 18th birthday, people don't go to the dentist and maintain their oral health care. My feeling is that there is a lack of access to dental services after Dental Benefits and therefore no on-going*
oral health care education. An ounce of promotion is worth a bank load of
dental treatment later on.

This comment is just as valid for anyone as it is for Māori. It highlights the need for oral
health education, especially at particular times in people's lives. There is also a high need for
appropriate oral health education resources and activities that are meaningful and relevant for
Māori if there is to be a difference made in Māori oral health.

The major impetus in the development of Māori-specific oral health education resources came
in the mid-to-late 1990s from three areas of the dental health sector: Māori oral health
educators, Māori oral health service providers, and individual highly committed and focused
School Dental Service managers. All three providers were desperate for Māori oral health
education resources and set out to develop them for their own use. What eventuated was the
production of some very creative and innovative resources by Māori for Māori with funding
that was sometimes not the easiest to obtain. Whilst the actual output of new Māori oral
health resources in this period was very small, their production was nonetheless very
significant.

The Māori oral health educators which were established as a result of the "Decile 1" funding
had very little (if any) financial resources for the production of Māori specific oral health
education material. Not to be thwarted, they were able to produce suitable oral health teaching
aids and resources from virtually nothing, using only their own creativity, imagination and
flair. Flip charts with pictures cut from magazines or images which were drawn and painted
by themselves were used. The writing of children's stories with an oral health theme and the
composition of oranga niho waiata (dental health songs) now appeared in kōhanga reo and
primary schools. Some oral health educators wrote short plays using stuffed toys purchased very cheaply as their teaching aid. The extent to which these oral health educators went to develop their own education material and resources was a clear indication of the passion with which they carried out their role.

Māori oral health service providers were also forthcoming in the development of Māori-specific oral health education resources. Te Whare Kaitiaki took a lead in this development with the production of a number of innovative resources including the New Zealand All Black captain Taine Randell cut-outs (1996); Te Kete Oranga Niho (A kitbag of oral health) (1999); Te Wero: Oranga Niho (The challenge is oral health) (2003); and pamphlets on oral health and diabetes, and oral health and coronary heart disease (2003). These resources are described in the appendix. Other Māori providers have virtually had to “beg, borrow and steal” everything they could to enable them to work effectively. The dentist working for Te Ātiawa Dental Service commented:

There is very little promotion stuff especially for Māori, so we just beg borrow and steal what we can. We have tried using all the material from the Ministry of Health and/or the DHB but I found they weren’t inspiring enough. So we ended up making a lot of it ourselves, like posters for instance. We found Māori images, ones that we can use and came up with our own resources. Some of the material came from Colgate, but we changed the pictures on them to put Māori faces on the pamphlets. You have to be very creative! The kete that were developed down in Otago have been great. The kids just love them.

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The good thing about that is that different providers in different areas can adapt that idea to their own use and fill a kete with their own things and resources.

There were also a number of School Dental Service managers who were also very proactive in the development of Māori-specific oral health education resources. In Taranaki, a bilingual booklet *Healthy Teeth, He Niho Oranga* was published, along with posters and stickers. In Otago, the School Dental Service collaborated with Te Whare Kaitiaki and Te Waka Hauora (the Māori health promotion unit of Health Care Otago) to produce *te kete oranga niho* (a kitbag filled with oral health promotion resources). In the Bay of Plenty, Pacific Health produced *te kete oranga niho, oranga tinana, oranga whānau* (a kitbag of oral health, physical health and family health) as an adaptation of the kete produced in Otago. That these were produced at all was due to the commitment of the people working in the respective School Dental Services at that time. As a result of these small efforts, some not insignificant progress was made in the provision of Māori-targeted oral health education resources where none previously existed. This development prompted a Ministry of Health official to comment on the ingenuity of Māori oral health promotion activities:

*Māori providers do more oral health promotion that anyone else in the sector. Oral health promotion is in the School Dental Service specifications because we put it there. But they don't always follow through with it for a whole host of reasons. But the things that Māori providers do with nothing is just amazing; it's their creativity, their imagination, their flair, their passion, their everything, together with the determination to improve oranga niho for our tamariki.*

Many Māori health community workers, who are committed to the promotion of oral health within their own communities, often find that they are stifled by a lack of basic information
and oral health promotion material. This was highlighted in comments from a Māori oral health hui on the West Coast⁵:

I went to a tangi and I saw five people sitting together, none of whom had any upper teeth. For them that was okay. For them, having no teeth was okay. What this means is that having no teeth becomes normalised. However, there is nothing like the kūmara vine. We must let Māori know what the issues are. So in fact it is not okay that those five people have had all their teeth pulled out. It is not okay that our rangatahi don’t go to the dentist.

We need to have the right information and we need to have it packaged in the right sort of way so that our people will take it on board.

As Māori, we have the greatest need and therefore we have the most to gain.

For Māori it is about informing Māori so that we have the right information.

The actual timing of oral health education can, on occasions, be very critical. A Māori health community worker⁶ described the time that it took to reach the “teachable moment” for oral health education with a particular whānau:

Yes, as a community health worker when I first go into a home I can see that the mother is so whakamā that their child has such bad teeth. They are so ashamed about that, that they don’t say anything. “Yes Tama’s fine, kei te pai,” that’s all. But more often than not, that is far from the truth. It takes a few visits for them to open up and let the barriers come down. It takes a few visits for the trust to develop before they open up and say, “well yes my

⁵ Hui kōrero, West Coast DHB Māori oral health hui, Westport, 20 May 2004.
⁶ Hui kōrero, West Coast DHB Māori oral health hui, Hokitika, 19 May 2004.
boy did have to go to the hospital and be put out to it, to have a tooth taken out.” And I’m thinking, “well maybe it might happen again.” It takes a while for a family to tell me these things. And that’s the point when I come in with the oranga niho education, promotion, call it what you want.

In order for Māori health community workers to be effective, they do require appropriate oral health education material. As one Māori health community worker stated⁷, “people want something they can hold in their hot little hand.” This is a very significant statement as it has considerable implications. Māori do value information and resources that are presented in a cultural format that is distinctly Māori. A common response⁸ from Māori who have accessed oranga niho resources is “this is ours; it belongs to us, no one else.” Hence, a strong sense of ownership is maintained which has the intention of leading to positive and healthy lifestyle changes. Māori oral health education resources are listed in Table 12.1.

These resources are described in detail in the Appendix. What is evident is that this area is still very much in its infancy and requires considerable development and funding. It is also necessary to consider these examples of Māori oral health promotion within the wider context of the society in which they are used.

The Māori oral health resources listed in Table 12.1 are concerned with lifestyle factors (oral health care behaviour and diet), public health (fluoridation), and oral health service factors (affordability, accessibility, appropriateness, acceptability). These approaches will not be sufficient on their own to make significant differences in Māori oral health without taking into account the social determinants of health.

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⁷ Personal communication, Māori health community worker, Hokitika, 20 May 2004
⁸ Personal communication, Māori health community worker, Te Ao Mārama Hui-Ā-Tau 2003
TABLE 12.1: Māori oral health education resources

<table>
<thead>
<tr>
<th>RESOURCE</th>
<th>PROVIDER / AGENCY RESPONSIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oranga Niho Oranga Kata</td>
<td>Public Health Commission, Wellington</td>
</tr>
<tr>
<td>(Pamphlet, March 1994, Code 4934</td>
<td></td>
</tr>
<tr>
<td>Colour-in figure, March 1994, Code 4933</td>
<td></td>
</tr>
<tr>
<td>Taine Randell (Stand-up figure)</td>
<td>Te Whare Kaitiaki, Dunedin</td>
</tr>
<tr>
<td>He Kete Oranga Niho, Oranga Tinana, Oranga Whānau (Kete)</td>
<td>School Dental Service, Pacific Health, Whakatane</td>
</tr>
<tr>
<td>He kete Oranga Niho Well Child Tamariki Ora. (Kete)</td>
<td>Waitamata DHB, Auckland</td>
</tr>
<tr>
<td>Te Whakapū Kōwhai Wai (Booklet)</td>
<td>Ministry of Health, Te Tai Tokerau</td>
</tr>
<tr>
<td>Healthy Teeth/He Niho Oranga (Booklet)</td>
<td>Taranaki Healthcare Ltd, New Plymouth</td>
</tr>
<tr>
<td>Bright Smiles Bright Futures (Package)</td>
<td>Colgate New Zealand</td>
</tr>
<tr>
<td>Kia mau tonu toku menemene (Pamphlet)</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Mouthguards in Rugby (Pamphlet)</td>
<td>Te Whare Kaitiaki, Dunedin</td>
</tr>
<tr>
<td>Tihei Mauri Ora: Diabetes, oral health and Māori; Tihei Mauri Ora: Coronary Heart Disease, oral health and Māori. (Pamphlets)</td>
<td>Te Whare Kaitiaki, Dunedin</td>
</tr>
<tr>
<td>Oranga Niho (Poster and waiata)</td>
<td>Ha Ora. Public Health Promotion Auckland Healthcare Services Ltd.</td>
</tr>
<tr>
<td>Free Dental care till 18 (Pamphlet)</td>
<td>Adolescent Oral Health Care Co-ordination Service, Lower Hutt</td>
</tr>
<tr>
<td>Oranga Niho Oranga Kata (Pamphlet)</td>
<td>Ministry of Health, Wellington</td>
</tr>
<tr>
<td>Te Wero: Oranga Niho (Card and toothbrush)</td>
<td>Te Whare Kaitiaki, Dunedin</td>
</tr>
<tr>
<td>Ka Tangara a Niho (Children’s story book)</td>
<td>Huia Publishers, Wellington</td>
</tr>
</tbody>
</table>

Sheiham and Watt (2000) stated:

Concentration on lifestyle often obscures broader determinants of health. This criticism of the emphasis on individual lifestyle as a cause and solution of health problems is particularly relevant to dentistry. The main focus of most oral health policy is on individual behaviour change. Such an approach diverts attention away from the underlying determinants of oral disease.
This statement could have been written with Māori in mind, as it is so pertinent to that section of the New Zealand population who are socio-economically disadvantaged. Whilst Māori oral health education resources are an essential aid in the crusade to improve Māori oral health, they are just one component in what is a very complex situation. If the wider approach (as intimated by Sheiham and Watt) is not considered, then it becomes very easy to fall into the trap of victim blaming. They present a common risk factor approach (an integrated approach) in which general health is promoted by controlling a small number of risk factors. This approach (according to Sheiham and Watt) “distinguishes between actions aimed at reducing ‘risk factors’ and actions promoting ‘health factors’.” This approach fits well with the kaupapa Māori approaches of whanungatanga (relationships) and Te Whare Tapa Whā, the Māori holistic approach to health and well-being.

Watt discussed “emerging theories into the social determinants of health” and their implications for oral health promotion (Watt 2002). Health education model interventions were focussed, he stated, on “defined diseases, targeted at changing the behaviours of high risk individuals.” Watt considered this approach to be limited in effectiveness. He described three contemporary theory bases for oral health promotion: firstly the life course analysis, which “considers an individual’s disease status as a marker of their past social position” (this was the thrust of the New Zealand report Improving Child Oral Health and Reducing Child Oral Health Inequalities (Thomson et al. 2003); secondly, the salutogenic model, which focuses upon the factors responsible for creating and maintaining good health; and thirdly, the social capital model, which focuses upon “the features of social organization, such as civic participation, norms and reciprocity, and trust in others, that facilitate co-operation for mutual benefit.” Whilst these theoretical bases are both valid and reliable, Watt presented another approach that is very relevant and meaningful for Māori. This is the community development approach, in which “empowerment, ownership, and participation of local people in the projects are central.” Watt stated that the community development approach has “not been utilised fully in oral health promotion.” For Māori, this is the most important approach of all.
exemplified by the Māori Health Commission (1999), and has been the *pou tokomanawa* (main support) of all Māori health services including health promotion. The community development approach is, for Māori, a manifestation and assertion of *tino rangatiratanga* (self-determination).

Nevertheless, regardless of the approach taken in Māori oral health promotion, the question has to be posed of how effective are these Māori oral health resources? Kay and Locker, in a major review of the effectiveness of dental health education, concluded that “the quality of the evidence pertaining to the effectiveness of dental health education is poor” (Kay and Locker 1996). It is not unreasonable to presume that such a conclusion could also be applied to Māori oral health education and promotion. However, there has never been an evaluation of these Māori oral health promotion resource and activities. Those Māori involved in the actual development of oral health promotion and education resources are naturally very proud of their work and outputs. At Te Ao Mārama, The New Zealand Māori Dental Association, Hui-Ā-Tau (annual conference) a session is devoted to *Show and Tell* in which the Māori dental health professionals, Māori dental health educators and Māori health community workers present their *mahi* (work) over the previous year. The response to this session is always the same:

> It is just great to see what is happening around the motu (island); to see what other people are doing; and to share our work, resources and experiences.

Whilst such anecdotal responses to oral health promotion programmes capture the “feel good” aspect of these activities, they have not been evaluated utilising the scientific methodology of health promotion evaluation.

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Blinkhorn provided a succinct account of the evaluation and planning of oral health promotion programmes. He stated (Blinkhorn 1993):

Health promotion programmes are designed to influence target populations through specifically planned interventions (process). These may have immediate effects (impact) as well as more long term influences (outcomes).

There are four types of evaluation of health promotion programmes: formative, process, impact and outcome evaluation (Waa et al. 1998):

Formative evaluation produces information that is useful for planning, refining and improving a programme as it is designed and implemented.

Process evaluation is concerned with documenting a programme including a consideration of how and why a programme achieved the results that it did.

Impact and outcome evaluation looks at the effects that a programme has had; it assesses whether a programme has reached its objectives.

One attempt to evaluate public health oral health promotion programmes was undertaken by the Bay of Plenty District Health Board (BoPDHB 2004). The evaluation was somewhat limiting in that it only utilised two dimensions:

1. Process – Developing a comprehensive picture of what oral health promotion activity (both ongoing and completed) has been implemented and undertaken in the BoPDHB region, by whom, for whom, and when.

2. Impact – Examining the effects of oral health promotion activity, to provide an understanding of why particular activities are more or less successful in order to improve future performance.
The report, *An Uphill Battle*, stated that “the evaluation was not intended to provide an understanding of long term outcomes resulting from oral health promotion activity – for example, the relationship between oral health promotion and caries-free rates in children.” It was more a stock-take of oral health programmes rather than an evaluation. It was not possible to gauge a clear indication of the impact of the oral health promotion activities as a number of providers were not forthcoming. The findings are presented below as they highlight the problems encountered in undertaking oral health promotion:

- oral health promotion can never overcome larger overriding problems such as lack of fluoridation, lack of dental therapists, and societal issues;
- all providers report being ‘stretched’ in terms of their capacity to undertake oral health promotion;
- there is considerable variation in the extent to which oral health promotion is being undertaken by providers. Much work is undertaken in an unsystematic, ad-hoc manner and the boundaries between health promotion and health education are blurred. Training is minimal or non-existent;
- There is a lack of co-ordination and information sharing between providers, and with the Dental Health Service;
- Providers have failed to undertake adequate evaluation of their oral health promotion activities;
- Work to promote fluoridation of water supplies is minimal, reflecting the workloads providers are facing, and the belief this would be a ‘full-time job’ if it were to be tackled effectively;
- Māori health services believe that much of the health promotion activity that is undertaken is inappropriate for Māori children and their whānau, even when it is delivered by Māori health promoters.

The question arises of whether the same picture would emerge in other areas of the country with regard to Māori oral health promotion. As the Bay of Plenty has a very high Māori population, it would be reasonable to assume that the answer would be affirmative. However,
regardless of the disheartening results of this particular evaluation, anecdotal reports indicate that, in particular Māori communities in particular areas, oral health education would have resulted in some increase in enrolment in the School Dental Service, some increase in the enrolment in the Dental Benefit Scheme, some change in dietary behaviour with a reduction in sugar-diets, some change in oral health care behaviour regarding regular tooth brushing, and some improvement in keeping dental appointments. In other areas (or with some individuals) there will be no response at all to oral health education initiatives, for whatever reason. Watt concluded that "oral health promotion has been poorly and inappropriately evaluated in the past" (Watt et al. 2001). He advocates that "evaluation methods and measures used should reflect the nature of contemporary health promotion practice." There have previously been two models put forward for measuring the effectiveness of health services for Māori: firstly, Ropiha (1994) developed Kia Whai Te Māramatanga (Measuring the effectiveness of health messages for Māori); and secondly, Cunningham (1995) developed He Taura Tieke (Measuring effective health services for Māori). However, whilst both models may have been appropriate for their respective tasks in their time, neither model is appropriate as a Māori health promotion evaluation tool. Both models are merely check lists of items in a process of determining the effectiveness of a health service. Therefore, it is timely for a Māori model of health promotion evaluation to be developed as a logical progression following the development of Te Pae Māhutonga. If such a model was in existence and utilised in the evaluation of oral health promotion in the Bay of Plenty, a quite different picture may well have emerged.

Kay and Locker conclude that “at a very minimum, the health professionals have an ethical responsibility to disseminate information about disease and its prevention to the whole population irrespective of what the population does with that knowledge.” Māori have been attempting to do just that, with very mixed results. The improvement of Māori oral health

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10 Verbal reports at Te Ao Mārama, the New Zealand Maori Dental Association annual conferences.
requires Māori-specific oral health education and promotion as an essential part of Māori oral health services. Mr P Hunter\textsuperscript{11}, past Chief Advisor, Dental Health, stated:

\textit{Drilling and filling will not solve the problems of dental caries.}

\textit{Prevention and health promotion is the only way to go.}

This is an activity that must be publicly funded. The 2004 National School Dental Service Review identified a lack of education and health promotion within the School Dental Service, prompting \textit{iwi} groups (and others) to state that this was one of the most important issues to consider as it was “one of the key areas that was most likely to contribute towards reducing inequalities” (Meyer 2004). However, this is a very contentious issue. Gift discussed “the range of social factors which are either correlates or determinants of oral disease prevention, or health promotion strategies” She made the point that ethnicity, as a measure of traditional values, affects individual knowledge, attitudes and behaviours. In the United States, race and ethnicity are highly correlated with measures of oral health, oral hygiene behaviours, overall use of dental services, and receipt of systematic dental care (Gift 1993). That situation is no different to the situation in New Zealand. Blinkhorn highlighted the complaint of many dentists that “while oral health promotion offers a positive route to good oral health, in practice patients do not seem to change their behaviour” (Blinkhorn 1993). He explained this in part, by stating that “patients bring with them the values and norms of their own community and if oral health is given a low priority the messages given by the dental team may well be diluted or forgotten.” Broughton had also drawn attention to the low priority that oral health had for many Māori (Broughton 1993b).

Reducing inequalities is a major health policy of the present government. To reduce oral health inequalities for New Zealand Māori, using oral health education as one strategy, may prove to be more difficult than first realised. Schou \textit{et al.} (1994) stated that “health education

\textsuperscript{11}Comment at the national Water Fluoridation Forum, Wellington, 2 November 2004.
has often been suggested as a way to improve health.” They concluded that “health education, as currently practised, is not a means of reducing inequalities in health, but on the contrary, is something which contributes to the perpetuation of such inequalities.” They also suggested that “inequalities can be created by dental health education.” They based this conclusion on their study in which the oral health (measured by oral hygiene and gingival bleeding) in 5-year-old children improved significantly in children from non-deprived schools over a similar group of children from deprived schools following a dental health education campaign. A widening of health inequalities for New Zealand Māori and Pacific populations was reported in a study in which New Zealand Census data was linked with mortality (Ajwani et al. 2003). The key finding was that mortality rates steadily declined over the twenty year period from 1980-1999 for both males and females and at all ages for the non-Māori and non-Pacific ethnic group. However, both Māori and Pacific ethnic groups showed little change resulting in a widening of the gap in survival chances between the ethnic groups over the 20 years. Although this study was concerned with mortality, it was the Māori and Pacific ethnic groups which were found, not only to be at a disadvantage, but the gap in this disparity appeared to be widening. It would require another national adult oral health survey to determine the current oral health status of Māori and non-Māori and to determine the nature and extent of oral health inequalities between the two groups. That there would be disparities is not in doubt. The challenge would come in the development of intervention strategies that would effectively reduce those disparities. When that day comes, it should be a requirement that the development of new Māori oral health education resources and campaigns include a robust methodology for their evaluation.

12.4 Te Kōrero (The Discussion)

In their study of dental health services and Māori people, Broughton and Koopu (1996) made the recommendation that the “dental profession must make dental health messages more effective for Māori people”. Durie’s model of Māori health promotion, Te Pae Māhutonga, affords the appropriate vehicle for this to occur. Based on the Southern Cross, Te Pae
Māhutonga, has been used to depict the six key elements for Māori health promotion: *Mauriora* (access to Te Ao Māori); *Waiora* (environmental protection); *Toiora* (healthy lifestyles); *Te Oranga* (participation in society); *Ngā Manukura* (leadership) and *Te Mana Whakahaere* (autonomy). These elements have been described utilising *oranga niho* promotion as appropriate examples. What is now required is a Māori model for the evaluation of Māori oral health promotion.

The three Māori oral health service providers reviewed in this thesis (Te Ātiawa Dental Service, Tipu Ora Dental Service and Te Whare Kaitiaki) all use the *oranga niho* education resources that are currently available. Although small in number, those resources that have developed over the last decade have been very significant. They reflect the creativity, inventiveness and flair of the small number of Māori working in this field. They also highlight the passion of the people involved who are committed to making a difference for their people. The significant point for Māori (and for the oral health promotion and education activities that have been undertaken so far) is that there are Māori people who are determined to make an effort with the support of the dental profession. A beginning has been made; it must now be able to grow, flourish and make a difference.
Chapter 13

Whakapakari

(Capacity Building)

13.1 Te Kōrero Tuatahi (Introduction)

Williams (1971) translates the word “pakari” as “matured, ripe” or “strong, hard, sturdy”. Ryan (1974) translates the word “whakapakari” as “make mature” or “strengthen”. In order to strengthen a particular entity, supporting structures must be put in place. In a contemporary context, that support can be mātauranga (knowledge, information, learning) and the application of that knowledge for a beneficial outcome. The term “whakapakari” is therefore an appropriate term to describe capacity building within Māori organisations. Te Puni Kōkiri, the Ministry of Māori Development, has defined capacity building as “a process which seeks to strengthen the ability of whānau, hapū, iwi, Māori organizations and Māori communities to build the strategies, systems, structures and skills that they need to control their own development and achieve their own objectives” (Te Puni Kōkiri 2004a).

Since the Labour Government came to power in 1999, there has been an increasing emphasis on capacity building of, by, and for Māori as a key strategy for initially “closing the gaps” and subsequently to reduce disparities. Capacity building was intended to be a “state-sector-wide initiative” with various agencies “working together to respond appropriately and effectively to the needs of whānau, hapū, iwi, Māori organizations and Māori communities” (Te Puni Kōkiri 2004b). The Hon. Parekura Horomia, Minister of Māori Affairs (2000) stated that “building capacity can close several gaps with one hit. If you educate someone well, then they have a better chance of getting a good job, a good house and a better life for their children.” Horomia (2001a) summed up capacity building as “Māori development by themselves for Māori.” Te Puni Kōkiri described capacity building as supporting “whānau,
hapū, iwi. Māori communities and Māori organizations to develop in their own way” by increasing the ability of these entities to solve local issues and to achieve their respective goals (Te Puni Kōkiri 2004). In a press statement regarding the 2001 Budget, Horomia said that it “contains many initiatives to strengthen Māori communities and local economies” (Horomia 2001b). He described capacity building as a three-step process: firstly, Māori communities set their own direction; secondly, Māori communities secure the right resources to do the work; and thirdly, ensuring that both the short and long term goals are met and that the resources are well used. Whilst much of the mechanisms and approaches for capacity building pertained to Māori business and economic development, they have also been applied to the health sector.

The Hon Annette King, Minister of Health, stated that “a partnership between Māori and the Crown will see Māori health issues addressed at all levels of the health system (King 2000c). Effective partnerships will lead to more effective services for Māori, greater participation by Māori in the health workforce and better access for Māori to health services... a growth in Māori participation in the health sector, and a measurable improvement in Māori health.” The Minister of Health outlined a proposal for options for strengthening the Crown’s partnership with Māori at the District Health Board (DHB) and other levels for the funding and provision of services (King 2000b). This proposal articulated the Government’s support for effective partnership arrangements with Māori that “contribute to Māori health gain and improve relationships with Māori under the Treaty of Waitangi.” It was recognised that capacity building throughout the sector was integral to an effective partnership. The New Zealand Public Health and Disability Act (2000) reformed the infrastructure of the health sector by the abolition of the Health Funding Authority and the establishment of District Health Boards. The Act included reference “to recognise and respect the principles of the Treaty of Waitangi... with a view to improving health outcomes for Māori.” Part 3 of the Act “provides for mechanisms to enable Māori to contribute to decision-making on, and to participate in, the delivery of health and disability services.” The Act also supports the notion

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of capacity building of Māori health services through the functions of the DHBs which are required “to continue to foster the development of Māori capacity for participating in, and contribute to, strategies for Māori health improvement.”

As a result of government policy and legislation since 2000, capacity building has become a recognised approach within government agencies as a key strategy for Māori advancement and to reduce disparities. Within the health sector, this was to be achieved through a number of actions which included specific health strategies, building on the gains already made, Māori provider development, Māori health scholarships and Māori representation on DHBs (Te Puni Kōkiri 2004b). However, whilst the government policy had been made quite explicit, the implementation of that policy with regard to the development of oranga niho services by Māori health providers had not occurred to the extent that Māori would have liked. That there were only nine Māori providers throughout the country in 2004 that provided some form of dental clinical services (and only six of these providers delivered services for all age groups), (Mauri Ora Associates 2004) belies the fact that there is still much to be achieved if government policy is to be realised for Māori oral health. The further development of Māori oral health services and the capacity building of Māori providers requires a willingness within firstly, the Ministry of Health to recognise the value of Māori oral health service provision, and secondly, the DHBs to make adequate resources available if any real progress is to be made. The reality is that publicly funded services often suffer through political expediency. A senior Ministry of Health official interviewed for this review commented:

_In the current political climate the Brash approach¹ will affect things; there are those within the health sector who are bureaucrats and will continue to be bureaucrats. On the other hand there are those within the sector that_
will be amenable to change. At the present time there are no specific directives.

This political expediency has created an uncertainty within the health sector at the governance and funding levels, resulting in very slow progress in the development of Māori oral health services. Consequently, the status quo is maintained which in itself creates a barrier for Māori capacity building. Adding to this uncertainty has been the lack of understanding and appreciation within the dental health sector of what Māori providers had been trying to achieve in the development of oranga niho services. An advisor responsible for oral health within the Ministry of Health stated:

*I do believe in kaupapa Māori services. This is a view shared within the Ministry of Health but not within the oral health sector at large.*

This lack of understanding of Māori oral health services had, in the past, led to some conflict within the dental health sector as Māori health initiatives were viewed by some with suspicion and by others as a threat. In 1992, Te Whare Kaitiaki dentist was invited to participate in a community-based dental project at Rātana Pā, south of Wanganui, (Broughton 1995) which prompted some local resentment towards this Māori health initiative. In reality, the majority of patients who utilised this particular short-term dental service had not been not accessing any dental health care at all. That this Māori oral health service was subject to some negativity from a minority within the dental health sector came as no surprise to the Māori dentist as, at that stage, *kaupapa Māori* services were in their infancy and had not established any real profile. Subsequently, an approach to raising the awareness of *kaupapa Māori* services was offered by a Ministry of Health official:

*Education is required so that the sector is made more aware of kaupapa Māori services. The question is, how do you do that?*
That in itself is another barrier, the lack of a means of promulgating to the wider dental health sector both the achievements that have been made in the provision of *oranga niho* services, and the aspirations of Māori communities for such services. A Ministry of Health policy analyst commented:

*A lot of mainstream managers, dental therapists, planning and funding units are gob-smacked at the mahi (work) that is going on in the community. They have no idea at all what Māori providers are doing with regard to oranga niho.*

Not only has there been a lack of knowledge of existing Māori oral health services, there have also been some disparaging attitudes directed towards those Māori providers. Two of the three Māori oral health providers in this review had experienced some negativity from individuals at some time in the early stages of their development. Te Ātiawa Dental Service dentist commented:

*Actually, after all the, how shall I put it, the initial ill feeling there was, they were pleased we were there because we saw patients that they didn’t want to see or treat.*

Te Whare Kaitiaki dentist at the University of Otago Dental School continues to experience racist attitudes and ill feeling from a small minority within the local dental health workforce, even after 16 years of operation. For example, a dental assistant\(^2\) enquired as to who can come to the clinic and how appointments were obtained. The assistant said that the only reason she asked the question was that “other people who work here say that it’s strictly for Māori people and not only that, you have to have a certain amount of Māori blood to attend.” She also commented that there is still “a lot of resentment about the clinic from some staff.”

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\(^2\) Personal communication, 12 July 2005.
Despite the negative attitudes, all three services in this review have been accepted in their respective areas by the wider dental health sector.

A further barrier to Māori oral health service capacity building is the compartmentalisation of dental health services in New Zealand. The school dental therapist, the dentist, the hospital dentist, the dental specialist and the clinical dental technician all have their specific scopes of practice and their particular client base. As the foundation of a kaupapa Māori service is whakawhanaungatanga (relationships), the driving force is an holistic approach which places the emphasis not on the individual, but on the collective, including a collective of health professionals. Whakawhanaungatanga is the basis of a whānau ora (health of the family) approach to Māori health gain. It is also the overall aim of He Korowai Oranga Māori Health Strategy, which focuses upon “Māori families supported to achieve their maximum health and wellbeing” (King and Turia 2002). The distinguishing feature of a whānau ora approach is that it is inherently kaupapa Māori. The significance of this for Māori is that, in many cases, it eliminates a potential barrier for the Māori patient who may be hesitant about accessing a mainstream service. This was highlighted in the Ministry of Health video (1994) A Better Way (concerned with standards for needs assessment for people with disabilities) in which a Māori health community worker commented:

> When whānau are coming here, particularly from different iwi, they know the process; it’s not foreign, and that within itself creates an environment of safety. We as clinicians, or whatever, don’t have all the answers and there are ... in a lot of situations, the whānau themselves that we are working with have a lot of the answers. It’s all about creating the environment to allow them to feel safe about, you know, hey, I know how to do this.

Although this comment was referring to a kaupapa Māori mental health service, it could just as easily refer to a Māori oral health service. The characteristics of a kaupapa Māori service
are universal to all types of Māori health service provision. The Manager of the Lakeland Health School Dental Service\(^3\) was very supportive of the concept of a *whānau ora* approach, as maintaining the oral health of the whole *whānau* would help to ensure good oral health among *tamariki*:

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I \text{ have no hesitation in supporting the University of Otago Dental School community dental project at the Tūnogonī Maraē because I know that whatever we do for the oral health of the parents, it will have enormous spin-offs for the oral health of the children. If the parents have good teeth the children will have good teeth.}
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*The Review of Māori Child Oral Health Services* (Mauri Ora Associates 2004) very strongly supported the *whānau ora* approach, and recommended that Māori oral health providers have flexible contracts which allow them to adopt the *whānau ora* approach. For example, Tipu Ora Dental service “would love to be able to provide dental treatment for the mother at the same time that they bring their *tamariki* to the clinic for dental care\(^4\).” As they only have a contract for dental care for pre-school children, this is not possible under their current contract. Māori prefer to operate with a seamless service between the various components of the dental health sector, rather than have demarcation and factions. A Māori health community worker for a child wellness programme commented\(^5\):

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\text{What we would really like is that when the mother brings her tamariki in for dental care, then she can also receive dental care at the same time. If the child needs additional care over and above that provided by the}
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\(^3\) Personal communication, Mrs Lois Jackson, Manager, Lakeland Health School Dental Service, July 2003.

\(^4\) Personal communication, Tipu Ora Administrator, July 2004.

\(^5\) Personal communication, Te Ao MArama hui, Rotorua, 2004.
Although a service for all age groups under the one roof is the preferred option for Māori oral health providers, it only occurs with a very few providers. Consequently, Māori providers have tended to just get on with delivering their service in the way that they know best, with the resources that they have available under their contracts. A Ministry of Health official commented:

Kaupapa Māori services have one particular thing that is so important:

the thing for Māori is, “we own it”.

Therein lies the essence of a kaupapa Māori service, ownership of the service by Māori. It is this single ideal that drives Māori providers to build the capacity of their service.

The first step in capacity building described by Horomia was for “Māori communities to set their own direction.” The direction in which Māori wish to go with regard to oranga niho services is to achieve “hei oranga niho mā te iwi Māori” (good oral health for all Māori) through the provision of accessible and affordable kaupapa Māori services (Broughton 1997). This is the kaupapa (philosophy) of Te Ao Mārama (the New Zealand Māori Dental Association) which has been widely promulgated through their newsletters. A Māori health community worker commented:

We provide a good service to our people in a whole lot of areas. What we would like to do is to have our own dental surgery as well to complete the

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6 Te Ao Mārama publishes regular newsletters to its members and Māori health providers.
package. We have a goal for oranga niho. Now we just have to persevere
down that pathway until we get it.

It is, however, the second step in capacity building (as outlined by Horomia “to secure the right resources to do the work”) with which Māori health providers have experienced considerable difficulty. The small number of existing Māori oral health providers who deliver clinical services tend, in the main, to provide services for mokopuna and/or tamariki by a school dental therapist who is community-based rather than school-based. They are therefore seen as being outside the traditional mainstream mode of service provision for this age group. This perception becomes another barrier with which Māori providers have to contend as they attempt to build their capacity in the provision of their service. A Māori health administrator commented:

_Within mainstream they are not willing to instigate any innovative or creative service outside mainstream._

However, a Ministry of Health official interviewed for this review noted that Māori providers were not to be put off or thwarted by such views:

_Māori oral health providers just oozed it; they have an absolute determination to keep going with the initiative. My observation is that the School Dental Service does not have that to the same extent; there is a low morale within their workforce and they do not have the same passion._

Even though the willingness was there, there was little that Māori providers could do if the right resources were not forthcoming. The major barrier to the capacity building of Māori health providers to either further develop their existing services, or to establish a new oral health service, is access to funding. Māori providers had found that, not only were financial
resources difficult to obtain in the first place, when funding that was made available, it was often insufficient to cover the dental treatment needs of their Māori client base. Māori providers interviewed in this review commented:

The big issue is funding; Māori oral health services are grossly under funded.

The School Dental Service is funded at the rate of about $75 per child, but some Māori services receive funding at half this rate, about $35 per child.

Māori oral health services also see and treat children with disabilities who require special needs and there is no additional funding for this.

A Ministry of Health official had even identified an instance of gate keeping by a government agency with regard to funding for emergency oral health care for people on a low income:

In one particular area it was revealed that the WINZ office withholds the limited funding available. The patient, that is, adults on a benefit, can't always get the support they are entitled to.

The third step in capacity building (as outlined by Horomia) was to ensure that that both the short and long term goals are met and that the resources are well used. There is no disagreement with this intended outcome except that it may be difficult to achieve because of constraints and requirements imposed by the funding agency. A cause for dissension is the required reporting and accountability process. A Māori health administrator commented:

Funding for oral health services under a Māori health umbrella is different altogether; the Māori provider is always under the microscope having to provide continuous reports.
The third step is totally dependent upon the second step being achieved. This, in turn, is dependent upon adequate funding being made available.

13.2 Capacity Building Of A Māori Oral Health Provider

Once a Māori oral health service has been established and is up and running, there is a continuing need to both improve the service and to expand it in order to effectively meet the dental health needs of a growing client base. There is a need to build the capacity of the provider organisation. The three Māori oral health providers in this review identified a number of issues in their respective services that were required if they were to build their capacity to ensure that their service provision would meet the health needs of their own community. The main issue was additional funding for such items as, firstly, maintenance of dental equipment; secondly, ability to provide an on-going adequate salary for the dental operator; thirdly, the ability to undertake oral health education; fourthly, the provision of mobile services; and fifthly, the provision of emergency dental care. These issues were not as critical for all three services to the same extent, highlighting the vulnerability of a community-based service compared to a mainstream service. Two further issues in capacity building were the nature of community relationships in oral health service delivery and the Māori oral health workforce.

In any dental service, once the dental equipment is installed and operational, there are ongoing costs for repairs, maintenance and upgrading. The existing contracts for the provision oral health services between a Māori provider and a DHB may not include this cost. In private practice, such costs are absorbed within the overall running of a general dental practice, but a Māori oral health service that mainly treats low-income adults may not have the additional resources for the maintenance of equipment. When the need for this arises, the costs have to be borne by the Māori provider; this is funding that would otherwise be used in
small contract with the Taranaki District Health Board to deliver oral health education and was able to employ a part-time oral health educator. The dentist commented:

We had a contract for a dental health educator for two years. She worked with the pre-school children, primary school children and adolescents. One of the good things about the position was that the doctors or practice nurses at the Medical Centre would refer patients and their whānau to see her directly if they thought it was necessary.

The oral health education activities of Te Ātiawa Dental Service included the organization of oral health days and participation in local health expos for both primary and secondary schools in the New Plymouth area. These were, according to the dentist, “well attended and well received.” He commented:

The kids just loved all the giveaways which we were able to provide.
This was just another way of getting tooth brushes into the homes.

The Tipu Ora Dental Service also engaged in similar activities in their own area. When they were able to secure a contract for a Māori oral health educator, the capacity of their service built significantly as they were able to gain direct access into local kōhanga reo and kura kaupapa. Te Whare Kaitiaki in Dunedin has also been an active participant in local Māori health expos and has been able to provide new Māori-specific oral health education resources. However, in order to do this, considerable effort was required to obtain adequate funding for the development and production of these oranga niho resources. A consumer at one Māori health expo commented:

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8 Oral health educators provide education on oral health and well child services to caregivers and whānau of pre-school children.
9 Personal communication, Māori Health Expo, Dunedin Museum, 18 August 2004.
We always love your stall because you always have the best freebies!

The use of Māori oral health education resources by Māori providers also helps to maintain their profile within the Māori community. The production of a pamphlet outlining the oral health services offered and how to contact the service was also an essential part of establishing and maintaining a public profile. Although all three providers in this review have engaged in a number of on-going public relations activities, they have done so at some cost, as marketing activities were not funded under their existing contracts. Te Ātiawa dentist commented that he has to “beg, borrow and steal everything I can in order to provide some tangible oranga niho resources for the community which is essential to maintain any semblance of public profile.” Te Whare Kaitiaki has been in existence for 16 years and, in that time, has developed a track record for consistency of service and has become widely known throughout its local Māori community. An important initial strategy was the distribution of a pamphlet outlining details of the service offered which was funded through a teaching budget and not part of a service contract. The Tipu Ora Dental Service found that the maintenance of a community profile was crucial, as they are situated in the central North Island and have to respond to the transient nature of the population, with some Māori people moving into and out of the area depending on employment opportunities. All three Māori oral health providers in this review recognised the importance of maintaining a profile within their respective communities. Although many Māori patients do not wish to access the services on a regular basis, they certainly want to have confidence in the knowledge that they are there when needed. Capacity building for Māori oral health providers therefore requires resources and funding in order to continually promote and maintain their profile within their respective communities.

A mobile dental service is able to go out to the community it serves in order to make the service more accessible to the client base. The School Dental Service has been operating mobile services for decades using caravans and, more recently, sophisticated containerised
clinics or large vans for largely rurally isolated communities. However, the last five years have seen the growth of mobile services in urban communities where large populations may not have dental clinic facilities in newly built schools. Mighty Mouth is one such provider which visits both primary and secondary schools in and around Auckland. Māori oral health providers have also recognised the value of mobile services to supplement their fixed clinic. Te Tai Whenua O Heretaunga in Hastings is one such provider which utilises mobile equipment to provide dental services at Hastings Boys High School. Te Ātiawa Dental Service has utilised mobile services on a short-term basis, utilising equipment on loan from the local School Dental Service. These have occurred to support oral health education activities and screening rather than to provide an on-going treatment service. The Tipu Ora Dental Service has been successful in going out to kōhanga reo and kura kaupapa in the Rotorua area to provide a service. This has been more convenient for the schools, as the service is on-site. However, in order for the dental service to access these Māori language learning institutions, it has been necessary for it to provide a fluent Māori speaker to accompany the school dental therapist. This reinforces the requirement for flexible contracts with the funder, as the Māori speaker is not funded under the contract with the DHB. Te Whare Kaitiaki does not provide any mobile services. However, Te Whare Kaitiaki has utilised mobile dental units on loan from the Lakeland Health School Dental Service for its annual week-long final year dental student clinical attachment at the Tunohopu Marae at Ohinemutu in Rotorua. Both Te Ātiawa Dental Service and the Tipu Ora Dental Service recognised the importance of mobile services in building their capacity to provide effective and accessible services for their respective communities.

The provision of emergency dental care (immediate care for pain and/or infection) has also been identified as an important component in building the capacity of Māori oral health services. Māori, Pacific peoples and low-income people have the poorest health in New Zealand, and they tend to be high users of after-hours services, especially at hospital accident and emergency or casualty departments. For example, this was a particular problem identified
by the Māori primary health care provider, Te Raukura Hauora O Tainui in the North Island10. To meet this need, they were responsible for a primary health care clinic which opened at Middlemore Hospital in South Auckland adjacent to the hospital’s Accident and Emergency Department. This clinic catered for those patients who presented but were not considered to require accident or emergency care. This service did not provide dental care, however. The provision of emergency dental care was an issue for both Te Ātiawa Dental Service and Tipu Ora Dental Service. At Te Ātiawa Dental Service, patients presenting with pain and/or infection were always seen by the dentist. In the evenings or weekends, they were seen through the “goodwill of the dentist” or referred to the New Plymouth dental after-hours service. However, when Te Ātiawa Dental Service closed, all patients seeking emergency dental care were referred to the Dental Unit at Taranaki Base Hospital. Te Ātiawa dentist commented that “this put an added strain on those patients” when they found that the Māori dental health service was no longer operating. At the Tipu Ora Dental Service, a patient may present seeking dental care at a time when the school dental therapist is not always available. An administrator for Tipu Ora commented:

_The problem is that our dental therapist is not here for the whole year and that causes difficulties when mum or dad brings in their tamariki who is in trouble with a sore tooth. Then we have to chase around and find a dental therapist or a dentist who can see the child._

The school dental therapist may be either working at a local school, undertaking in-service training, or off during the school holidays. The provision of emergency dental care is not a problem for patients of Te Whare Kaitiaki, as they are able to be seen all through the working week at the Diagnostic Clinic at the University of Otago Dental School, where, if required, they can be referred to the emergency dental care clinic for low-income people. During the

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10 Personal communication. Mr W McLean, CEO Te Raukura Hauora O Tainui.
weekend, patients are able to access the Dunedin after-hours dental service or be seen by a dental house surgeon if necessary. The ability to deliver emergency dental care services was identified as an important capacity building strategy for a Māori oral health provider.

The establishment and maintenance of relationships with other providers (particularly Māori providers) and the Māori community is an essential component of capacity building for a Māori health service provider, if the service is to grow and develop. Such relationships ensure a steady flow of clients and reinforce the confidence in the service from other providers. Te Ātiawa Dental Service had an unexpected problem by virtue of their name. Many local people assumed that Te Ātiawa Dental Service was for Te Ātiawa iwi (people who were of Te Ātiawa whakapapa or genealogy) only, and this was a barrier to access for some people. Consequently, discussions were being held to change the name of the service to a name which has an all-embracing connotation rather than an iwi-specific name. The Tipu Ora Dental Service carefully built close working relationships with the local kōhanga reo and kura kaupapa so successfully that they have been able to access those institutions and provide dental care to the children in those schools. In Dunedin, Te Whare Kaitiaki has maintained relationships with the local Māori providers (Te Waka Hauora, Araiteuru Whare Hauora, Te Oranga Tonu Tanga and Te Rōpū Tautoko Ki Te Tai Tonga) such that their staff not only refer, but may also bring in their clients for dental treatment when they have identified such a need. Te Waka Amo, a special needs secondary school in Dunedin, also accessed the University-based clinic to ensure that their pupils continued with routine dental care.

Another issue central to capacity building for a Māori dental health service is the Māori dental health workforce. Whilst this has been discussed in detail in chapter 9, it is worth noting that to build their capacity, a Māori health provider requires a Māori health workforce. In practice, this is not necessarily the case, as many Māori health providers employ non-Māori staff. All three dental providers in this review have both Māori and non-Māori staff. At Te Ātiawa Dental Service, the dentist is Māori and they have employed both Māori and non-
Māori dental assistants. They have also worked closely with a Māori school dental therapist. At the Tipu Ora Dental Service, the foundation dental therapist was of Māori and Niuean descent. Subsequent dental therapists have been either Māori or non-Māori. The kuia for Tipu Ora commented that, whilst she would prefer to have Māori staff, the local Māori dental therapists “prefer to remain working in their schools where they have worked for many years.” Although Te Whare Kaitiaki at the University of Otago Dental School is supervised by a Māori dentist, the students who are rostered to work in the clinic come from very diverse ethnic backgrounds, including European, Māori, Pacific, Asian and Middle East origins. The Māori patients who access this service have, in the main, enjoyed interacting with these students and make a point of thanking them for their professionalism and clinical responsiveness. There is no doubt that the number of Māori oral health services will increase over the next decade, with a corresponding demand for Māori dentists and dental therapists. In order to build their capacity, Māori oral health providers see a strong need for a growing Māori oral health workforce.

13.3 A Model Of A Kaupapa Māori Oranga Niho Service

In order to build the capacity of a Māori oral health provider it is logical that a model should be implemented that has been proven to work. One such model was that established by the Māori provider, Te Tai Whenua O Heretaunga in Hastings which consists of a school dental therapist and a dentist working as a team as part of an established Māori health provider. This publicly funded service caters for the treatment needs of all age groups in a seamless operation. The Māori providers, Te Whānau O Waipareira Trust in West Auckland and Hauora Whānui in Kawakawa have worked along similar lines. They have at times employed both a dentist and a school dental therapist having been able to develop their own particular oral health service, in their own particular way, to meet the dental treatment needs of their own communities. Of the three oral health providers in this review, only Te Whare Kaitiaki in Dunedin has the means to cater for all age groups in a seamless service delivery model. As
this clinic is based within the University of Otago Dental School, it is in the fortunate position of being able to ensure that patients of all age groups receive appropriate dental care because of the whole range of services and expertise that is available within that institution. Te Ātiawa Dental Service in New Plymouth is staffed by a dentist and has worked closely with a Māori school dental therapist, but they were not co-located at the same place. They have however, cooperated in a range of Māori oral health education activities and health promotion days. Ideally, Te Ātiawa Dental Service would prefer to simulate the model that operates within Te Taiwhenua O Heretaunga. Tipu Ora Dental Service in Rotorua is staffed by a school dental therapist and would also welcome the establishment of an oral health service based on Te Tai Whenua O Heretaunga model. Tipu Ora Dental Service had experienced some difficulty when patients required referral to a dentist, as the treatment need was over and above the scope of practice of the school dental therapist. The referral process merely increased the delay in the patient receiving definitive treatment and this added to the stress of the patient and their whānau. In an effort to overcome this problem, Lakeland Health\(^{11}\) appointed a “community dentist” in 2004 to work with and support the school dental therapists in the Rotorua area. Whilst this move was designed to reduce the referrals from the school dental therapist, the community dentist was not contracted to treat adults. What is required for both Te Ātiawa Dental Service and Tipu Ora Dental Service to build their capacity (in order to provide a seamless service catering for all age groups) is a DHB contract similar to that between Te Tai Whenua O Heretaunga and the Hawkes Bay DHB.

An ideal model for a Māori oral health service also requires three specific activities: firstly, enrolment; secondly, attendance; and thirdly, treatment. These activities were outlined in \textit{The Review of Māori Child Oral Health Services} (Mauri Ora Associates 2004). A contract for enrolment may be part of a Tamariki Ora (Child Wellness) contract or a Māori oral health educator contract. However, a requirement for attendance has not been part of any service

\(^{11}\) Personal communication, Te Ao Mārama Hui-Ā-Tau, Ōhinemutu, Rotorua, 12 February 2005.
contract apart from the Adolescent Oral Health Coordination Service which was specifically designed for adolescents to access dental care under the Adolescent Oral Health Service Agreement. A contract for dental treatment services is the most comprehensive of all but may include specifications on who may access the service (emergency care for low income adults; patients who live in a defined geographical area) which may (in turn) place some limitations on the provider. Not all Māori providers of oral health care have all three aspects (enrolment, attendance, treatment) as a service specification in their contracts. Therefore, in order for a Māori provider to build its capacity to deliver an optimal level of service, it would ideally require all three service specifications being part of the one contract. A further requirement for oral health education resources and activities would also be beneficial to compliment the service and to reinforce positive oral health behavioural changes. All three Māori oral health providers in this review have had quite different service contracts even though their goals and aspirations are the same.

Te Ātiawa Dental Service in New Plymouth has engaged in both enrolment and attendance activities, some funded through small short-term contracts, whilst other activities were funded through clinic overheads whenever possible. The dental health educator employed under a short-term contract achieved significant improvement in the enrolment of adolescents in the Dental Benefit Scheme. The follow-up stage of attendance was achieved through the implementation of a simple strategy that was very successful in ensuring that dental appointments were kept. A monthly draw for a $50 Warehouse voucher was instituted for all those adolescents who attended for dental care. The dentist commented that “once this got around, there were hardly any no-shows anymore.” Te Ātiawa Dental Service did not have a “fetch and carry” service but on occasions when the need arose, transport was provided for the patient. No funding was provided for transport but it was done as a service for the patient, with the cost being carried by the dentist. However, on the occasions when transport was provided, maximum use of it was made by the patient:
We provided a little bit of transport. But being an urban service most people were able to get in to see us. Having said that, there were occasions when we went to collect the odd patient ourselves. The trouble was, when we did that, they wanted us to take them here or there after the appointment. “Oh, do you mind taking me to the supermarket on the way home.”

Tipu Ora Dental Service in Rotorua utilised their kaitiaki (Māori health community worker) to enrol their clients in the service. They also provided a “fetch and carry” service to ensure that the infants attended for treatment which was not funded through their dental contract. This highlights the need for a wider scope of service provision (over and above the dental treatment services) to be included in a dental contract. This wider scope of service provision is the key to the capacity building of a Māori oral health provider. For this to happen requires an increase in funding from the DHB. Te Whare Kaitiaki at the University of Otago Dental School provides a full range of treatment services to all age groups but does not actively engage in seeking patients to enrol for the service or to provide transport to the clinic. The children of Te Kura Kaupapa Māori O Ōtepoti (the Māori language immersion primary school) attend the clinic, but the school provides their transport for a 15 km round trip. The provision of transport to the dental clinic has on occasions been found to be necessary if the patient is to access the service at all, even though they are not funded to do so. Māori providers have tended to extend the requirements of their service specifications to ensure that they are able to meet the needs of their client base.

13.4 Te Kōrero (Discussion)

Whakapakiri, otherwise known as capacity building was an approach adopted by government agencies in 2000 to enable Māori providers to deliver a more efficient and a more effective service with the intended outcome of reducing health disparities. Whilst Māori providers welcome such initiatives (spurred on by the need to continually develop, expand, improve,
and extend their service provision), there was one barrier that was often insurmountable: access to the “right resources”. A Māori provider requires adequate funding in order to build its capacity. For an oral health provider, the basic overheads, maintenance costs and other associated costs (transport, oral health education resources) are expensive. One particular strategy to build the capacity of a Māori oral health provider is the ability to provide a mobile service in addition to fixed clinical facilities. Whilst a Māori provider would like nothing more than to be able to take its service out to where the people are, such mobile services come at considerable cost. However, it has now been recognised that there are some failings in publicly funded dentistry for the under 18 age group in particular (Otago DHB 2005). The School Dental Service is, in some areas, understaffed with clinical facilities that no longer meet modern dentistry requirements (King 2005). In some urban centres, local dentists no longer take up DHB contracts for adolescent oral health care under the Dental Benefit Scheme (Otago Daily Times 2005). In a speech to the School Dental Service in March 2005, the Hon Annette King described her vision for the future direction of a child and adolescent oral health service (King 2005). She stated that the future will have “community based dental services with strong linkages to schools, Māori oral health providers and primary care; seamless 0-18 year-old structure, which has the flexibility to extend to whānau and adults; a focus on prevention and very early intervention; delivery through a mix of fixed and mobile facilities that are suitable for modern dentistry; an appropriate and skilled workforce; and nationally consistent dental data.” Māori providers fully realise that they are well positioned to take up such services and literally fill the gap in oral health service delivery. In order for this to be achievable, they must be in a sound position to build upon their existing capacity and capability. It is inevitable that there will be some very interesting developments in oral health service delivery by Māori providers over the next five years if both the Minister’s vision and Māori aspirations are to be realised.
Chapter 14
Whakamutunga

Conclusion

It is an undisputed fact that there are disparities in oral health status between Māori and non-Māori New Zealanders. In an effort to reduce these disparities Māori have sought to develop and deliver oral health services that meet their needs as Māori. This review of Māori oral health services has taken a journey through the dental health sector of New Zealand/Aotearoa looked at through Māori eyes. A kaupapa Māori methodology was developed to undertake this study based on seven criteria: Rangatiratanga (Māori Leadership); Whakakotahitanga (Unity); Whakapapa (Lineage); Whakawhānuitanga (Diversity); Whakawhanaungatanga (Relationships); Māramatanga (Enlightenment); and Whakapakiri (Capacity Building). These criteria formed an appropriate framework to organise and analyse the information that had been generated within a Māori cultural context, resulting in a research process that was both meaningful and relevant for Māori. In drawing this thesis to a conclusion, however, there have been a number of reports, press releases, and news items published in the first half of 2006, plus a number of hui (meetings) which all have a direct bearing on this kaupapa (topic) of oranga niho. It is important that they are included in this final chapter for completeness. Furthermore, these confirm and extend the conclusions reached on the basis of my research.

The first of these is the report (Mission to New Zealand) of the United Nations Special Rapporteur, Rodolfo Stavenhagen, on the situation of human rights and fundamental freedoms of indigenous people, published on 13 March 2006 (Stavenhagen 2006). The report focussed upon a number of identified priority issues including reducing
inequalities. The Special Rapporteur concluded his report with a “number of recommendations intended to help the parties concerned to bridge the existing gaps and consolidate the achievements obtained so far to reduce inequalities and protect Māori rights.” The recommendation on social policy stated:

Social delivery services, particularly health and housing, should continue to be specifically targeted and tailored to the needs of Māori, requiring more targeted research, evaluation and statistical bases.

Whilst much of the report was concerned with political representation, land rights, claims and settlements, this particular recommendation is of great relevance to Māori oral health. The Deputy Prime Minister, the Hon Michael Cullen, described the report as “disappointing, unbalanced and narrow” (Cullen 2006), and the Minister of Foreign Affairs, the Rt Hon Winston Peters said, “solutions to the issues we confront will not come out of fleeting overseas ‘experts’ visits with entrenched ideological views” (Peters 2006). Despite the negative response to the report by the Government the significance for Māori was that Māori issues were placed in an international forum as part of the increasing global awareness of the rights of Indigenous Peoples. In applying this recommendation to Māori oral health, this thesis has demonstrated that oral health services “should continue to be specifically targeted and tailored to the needs of Māori.” The New Zealand dental health sector would also benefit from targeted research concerned with the access by Māori to dental services, an evaluation of oranga niho education resources and the collection of accurate ethnicity data in publicly-funded dentistry.
In *te ao tawhito* (the pre-European world of the Māori), there was very little (if any) dental caries. The Māori cosmological view of the oral cavity demonstrates the importance of the mouth and teeth to overall health and well being; the mouth was the vehicle that expressed who you were as a person and established your *mana* within the *whānau*, *hapū* and *iwi*. With the coming of the European and a new culture imposed upon Māori, many traditional belief systems and cultural practices were either lost, diluted or adapted in order to survive. The spiritual connotations of the oral cavity appeared to have dissipated over time such that, today in *te ao hou* (the contemporary world of the Māori), the prevalence of oral disease within the Māori population gives rise to major concern. With the introduction of sugar into the diet and the subsequent deterioration of dental health, dental caries can be regarded as an introduced disease. Today, Māori as a population group do not enjoy the same oral health status as non-Māori across all age groups.

14.1 *Rangatiratanga* (Leadership)

The criterion of *rangatiratanga* provided an appropriate starting point for a review of Māori oral health services based upon the Treaty of Waitangi. This approach revealed four levels of response to Māori oral health: firstly, the government response; secondly, the health sector response; thirdly, the dental health sector response; and fourthly, the Māori response. The Government response to Māori oral health is determined by the principles and objectives outlined in *The New Zealand Health Strategy* and *He Korowai Oranga* (the Māori Health Strategy). An insight into a Government response to oral health came in the Speech from the Throne by the Governor General at the State Opening of Parliament on the 8th of November 2005 (Clark 2005). The Governor General stated that “special attention will be paid to children … there will be significant investments in improving dental services for children and young people over the next three years.” This
was enlarged upon by the Hon Michael Cullen, Minister of Finance in the 2006 Budget, which was presented in the House of Representatives on 18 May 2006. He stated:

Child health sees an additional four year $80.4 million investment. Just over half of this, $40.8 million, will allow for the creation of a seamless oral health service for all those under eighteen. The failure to invest in oral health in the 1990s has led to the first deterioration in the state of children's teeth on record. This must and will be reversed.

Māori providers will follow the development of this Budget intention with great interest. It may well be that a “seamless oral health service” entails the expansion of the scope of practice of the school dental therapist to include the treatment of adolescents. This in fact has now occurred with the provision for the treatment of adolescents being included in the service specification for child oral health services (DHBNZ 2006). For Māori this could entail a school dental therapist being regarded as a community dental therapist who could work within the organization of a community-based Māori health provider rather than being school-based. With the opportunity to have both fixed and mobile dental facilities, a Māori oral health provider would be well placed to meet the dental health needs of the under-18 age group for almost the whole community they serve. Such a service would also necessitate the requirement of a dentist and support staff to provide the back-up and clinical support for the dental therapist. This being the case, the inception of a “seamless oral health service” comes back to the model of a kaupapa Māori oral health service (a dentist and dental therapist with support staff, working as a team as part of an existing Māori provider). This was first put forward to the Minister of Māori Affairs in 1998; it was consequently proposed in the 1999 Budget, and resulted in a contract being awarded to Te Tai Whenua O Heretaunga for a new oranga niho service.
The health sector response to Māori oral health is determined by the Memorandums of Understanding between District Health Boards and local āti. In March 2005, the Minister of Health informed DHBs of the oral health vision which was based upon: firstly, a community-based dental service with strong links to schools, Māori oral health providers and primary care providers; secondly, a seamless 0-18-year-old structure with the ability to extend to whānau and adults; thirdly, delivery through a mix of fixed and mobile facilities, suitable for modern dentistry; fourthly, a focus on prevention and very early intervention; and fifthly, an appropriately skilled workforce (Whyman 2006). DHBs were then required to develop their own Strategic Asset Plans by June 2005. The Northland DHB (for example) based their oral health strategy on five priorities: fluoridation; workforce; whānau ora service; oral health promotion; and community empowerment (Northland DHB 2005). The whānau ora approach (as advocated by the Northland DHB) is a clear acknowledgement of kaupapa Māori oral health services. Whilst Māori providers may look with considerable hope at these ideals and plans, it is not unreasonable to surmise that some skepticism may remain because of current funding shortfalls. To date, Te Ātiawa Dental Service have not been able to secure funding to recommence their service, and Tipu Ora Dental Service have not been successful in gaining DHB funding to extend their operation to a “seamless service.”

The Public Health Advisory Committee also provided direction for the reduction of oral health disparities in children and adolescents (Thomson et al. 2003). This Committee recommended that the Minister of Health “directs the Minister of Health to fund evaluation of current Māori oral health initiatives.” This was subsequently done, with the Review of Māori Child Oral Health Services Report being published in December 2004 (Mauri Ora Associates 2004).
The dental health sector response to Māori oral health was determined by five activities (consultation, participation in the health sector, workforce development, Māori provider development, and mainstream enhancement). Whilst the levels of response to Māori oral health throughout the dental health sector have been both timely and important, it is the Māori response that is particularly significant. The driving forces for Māori have been threefold: firstly, the development of Māori oral health services; secondly, through the development of Māori oral health education resources and promotion activities; and thirdly, through the establishment of a nationally recognised voice for Māori oral health (Te Ao Mārama, the New Zealand Māori Dental Association). The emerging Māori leadership in oral health is the key strategy for the development of Māori oral health services. One of the recommendations of the Review of Māori Child Oral Health Services was that “Te Ao Mārama should be supported by the Ministry of Health and DHBs and be recognised as an important thread that brings together the Māori oral health workforce.” Te Ao Mārama consequently signed a contract with the Ministry of Health on 11 April 2006 “to enable the provider to develop as a National Māori Provider, by purchasing appropriate resources to communicate and promote Māori oral health issues.” (Te Ao Mārama 2006). The schedule included:

• Improved organization administration, presentation and planning through purchasing operating systems that enable Te Ao Mārama to accelerate their ongoing development and abilities to communicate effectively;
• Improved communication with Māori dental community and associated members;
• Involvement in the promotion of water fluoridation in Hamilton.

The value of the contract was $50,000 (plus GST), which will allow the organization to develop further and to provide the type of leadership that is required to meet the growing
needs of the future. This contract also enabled Te Ao Mārama to play an effective role in the Hamilton fluoridation campaign in April 2006.

However, despite the seemingly small but positive advances that Māori have made since 1990 in the development of both Māori oral health services and oral health education resources, Māori providers remain vulnerable to the machinations of politicians. In April 2006, the National Party health spokesman (Mr Tony Ryall) stated “just why a dentist needs to be bound by the Treaty of Waitangi escapes me. Teeth are teeth and people should get help on the basis of need, not race” (Otago Daily Times 2006). Mr Ryall was decrying the inclusion of clauses pertaining to the Treaty of Waitangi in DHB contracts with dental providers. Clause A7 of a DHB Provision of Oral Health Agreement with a dentist or dental provider (Part A: Standard Terms and Conditions) states:

Maori Health Priority

You agree that Māori health is a specifically identified health gain priority area. You must take into account our strategic direction for Māori health in terms of minimum requirements for Māori health as communicated to you by us from time to time. These minimum requirements are based on the Treaty of Waitangi crown objectives for Māori health and specific requirements negotiated with us from time to time.

The inclusion of this clause is to ensure that efforts are made by dental health providers to be responsive to an identified dental health need. The derisive statement by Mr Ryall was a continuation of the National Party policy of “one law for all New Zealanders,” initially promulgated by National Party leader Dr Don Brash in his 2004 Orewa speech. The Minister of Health (the Hon Pete Hodgson) responded immediately by stating that “on any analysis Māori children were a high needs group, which had rates of fillings and
dental decay over 50 per cent higher than Pākehā children." He also stated that “Māori children had a poor record of accessing existing services so it was vitally important DHB staff proactively promoted services to them” (Otago Daily Times 2006).

The statements by Mr Ryall demonstrate his lack of understanding of contemporary Māori society (based on whānau, hapū and iwi) and how Māori have used their societal structure to engage with the health sector. This point of engagement is the Treaty of Waitangi, which provides the framework (based on both the Articles and the Principles of the Treaty). The intended outcome is to work towards an improvement in oral health, a reduction in inequalities, a Māori health gain and a healthier New Zealand population. The negative statements by some political parties have not deterred both Māori and DHBs from upholding the one key element for Māori health gain: rangatiratanga (Māori leadership). For example, the Otago DHB in its newly published Māori Health and Disability Strategic Plan for Otago, states that, “it promotes Māori health and disability delivery systems that give effect to the Treaty guarantee of tino rangatiratanga” (Māori self-determination including Māori leadership), (Otago DHB 2006b).

14.2 Whakakotahitanga (Unity)

Whakakotahitanga is concerned with the concept of unity which also embraces a holistic view of health and well-being. As previously outlined, the model of Māori health and well-being (Te Whare Tapa Whā) provides an appropriate framework to describe the impact of oral disease upon Māori. The four dimensions (te taha tinana; te taha hinengaro; te taha whānau; and te taha wairia) and their application within a clinical setting form the pou tokomanawa (main supporting structures) at the very core of Māori oral health service provision. They have the potential to achieve positive oral health
outcomes for Māori in the treatment and management of oral disease. Two dimensions of this model with regard to Māori oral health have been highlighted in recent months: te taha tinana; and te taha whānau.

Te taha tinana (the physical dimension) provides the framework for describing Māori oral health status. A Māori analysis of the Māori cohort of the long-standing Dunedin Multidisciplinary Health and Development Study was completed by Koopu in 2005. She concluded that, “for a cohort of New Zealanders followed over their life-course, the oral health features of caries prevalence, caries severity, and periodontal disease prevalence are higher among Māori than non-Maori” (Koopu 2005). For Māori adults in particular, this was an important verification of what had been widely known for many years.

Te taha tinana also describes the health of the body. Obesity in children has become a major concern in New Zealand as well as in many other Western countries, particularly the United States. In March 2006, the West Coast DHB rejected the offer by Ronald McDonald House Charities of a “high-tech” mobile dental clinic (Westport News 2006). The offer was turned down by the West Coast DHB because the Government had intimated an increase in funding for improved dental services in the 2005 Speech from the Throne. However, this did not deter the West Coast nutrition health promoter from stating that “the move by the international McDonald’s Corporation to ‘sponsor’ dental units is part of a multi-million-dollar marketing ploy to boost junk food sales....World wide direct marketing to children was under the spotlight as a result of alarming levels of childhood obesity – which shared many risk factors with tooth decay.” It is no coincidence that the West Coast has a very assertive Māori health network spearheaded
by the local Māori Women’s Welfare League who subscribe very strongly to the tenets of Te Whare Tapa Whā.

With regard to the consumption of high-sugar drinks (which impact upon both obesity and tooth decay), the Minister of Health announced that “plans were being drawn up for the removal of soft drink vending machines from schools.” Some schools allow soft drink vending machines on their premises as it is a means of generating much needed funds for extra-curricular activities. It has always been an anathema to the author that the University of Otago Dental School has soft drink vending machines adjacent to the school’s cafeteria.

*Te taha whānau* (the family dimension of Te Whare Tapa Whā model) is vitally important in the provision of Māori oral health services. For example, a key element in the work of Te Tai Whenua O Heretaunga (a Māori health provider in Hastings) to improve the dental health of Māori is “to acknowledge and recognise the importance of whānau in the delivery of dental health services.” This was the theme of an address by Le Geyt to the International Network for Indigenous Health Knowledge and Development in Vancouver in October 2005. He described how “a visit to the dental clinic becomes a social occasion where everyone, not only patients but the entire whānau feels welcomed and comfortable” (Le Geyt 2005). This address was also significant for the fact that Māori health (or more specifically Māori oral health) was given a presence in an international Indigenous forum.

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1 Personal communication, Mrs June Robinson, Hokitika, 10 December 1997.
2 Hon Pete Hodgson, Minister of Health, National Radio Morning Report, 1 June 2006.
In conclusion, the significance of the Māori model of health and well-being cannot be underestimated. Te Whare Tapa Whā is a very important strategy or approach that can be applied in efforts to reduce oral health disparities, not just for Māori, but for all New Zealanders.

14.3 Whakapapa (Lineage)

The concept of oranga niho has its own whakapapa or lineage. It was first used to depict Māori oral health in a national campaign targeting Māori by the New Zealand Public Health Commission’s observance of United Nations World Health Day in 1994. Since then, it has become a well-established and accepted part of the Māori health sector. The latter half of the 1990s saw a determined effort by Māori working within the health sector (including both Māori health providers and mainstream providers) with the support of Te Puni Kōkiri to develop Māori oral health services. Oranga niho now encompasses three distinct strands: firstly, Māori oral health strategies; secondly, Māori oral health services; and thirdly, Māori oral health education and promotion. The driving force of oranga niho is tino rangatiratanga, or Māori self determination.

14.4 Whakawhānuitanga (Diversity)

The criterion of whakawhānuitanga (diversity) has highlighted the need for a diverse range of oral health services to cater for the unmet dental health needs of a diverse population. Where Māori providers have been able to establish an oral health service, they have evolved with their own unique structure, organization and service delivery in an attempt to meet their respective community needs. Consequently, a “one-size-fits-all” approach for Māori oral health service delivery would not be effective given the regional diversity of whānau, hapū, iwi and Māori community infrastructures and processes. In
February 2006, the Ministry of Health acknowledged that the challenges for a community-based dental service were to have a “reconfiguration of dental services whilst staying positive; and to keep oral health services on track while capturing a process of continuous improvement” (Whyman 2006). Once again, these sentiments fit the matrix of Māori oral health service provision which would allow services to be developed with the active participation of end users.

The three Māori oral health providers who participated in this review (Tipu Ora Dental Service, Rotorua; Te Ātiawa Dental Service, New Plymouth; and Te Whāre Kaitiaki, Dunedin) all evolved as a response to their respective community needs. They all faced numerous barriers in: firstly, their development (funding, clinical facilities and human resources); secondly, their implementation (administration); and thirdly, their operation (ongoing funding, co-operation, extent of the dental disease). That they were able to overcome the barriers was due to two driving forces: firstly, the relationships that each provider had established and maintained (with government agencies, with the health sector and with their own communities); and secondly, the passion which those providers had for the kaupapa of oranga niho and the health and well-being of their communities.

The unfortunate reality for Te Ātiawa Dental Service was that it was forced to close in September 2004 because of a lack of financial support. It is the intention, however, to re-establish the service once appropriate funding can be obtained through the District Health Board. Whether or not that will happen remains to be seen. As recently as March 2006, the Tipu Ora Dental Service was not successful in gaining funding to provide a seamless oranga niho service when application was made to their local DHB. Therefore, in the light of the $40.8 million additional funding that was announced in the 2006 Budget for “the creation of a seamless oral health service for all those under 18”, to maximise the gain in the provision of an oral health service to an under-privileged group, the most cost
effective approach would be to start by increasing resources for those providers who have established a proven track record. On the 8th of March 2006, the Executive of Te Ao Mārama met with the Minister of Health and Ministry of Health officials to discuss this very question. Mr Hodgson\(^3\) was very supportive of the *kaupapa* (aims and objectives) of Te Ao Mārama, and he supported the development of Māori oral health services, recognising that these were a significant component in the efforts to improve the oral health of New Zealanders. Unfortunately, he was unable to give any firm commitment at that time for an increase in funding, he did intimate that he was very positive about “taking things forward into the future.” Hence, the announcement was made of additional funding for oral health in the 2006 Budget on 18 May.

### 14.5 Whakawhanaungatanga (Relationships)

The criterion of *whakawhanaungatanga* (relationships) highlighted the extent to which Māori oral health providers have had to form positive working relationships with both government agencies and the health sector. Such relationships can (at times) be fraught with difficulties and uncertainties due, in the main, to the political climate of the time. One key relationship is that between the oral health provider and its local District Health Board. The maintenance of effective working relationships between Māori providers and the dental health sector is an essential strategy in the provision of Māori oral health services. At the conclusion of the *hui* between Te Ao Mārama and the Minister of Health, Mr Hodgson looked forward to a continuation of his relationship with Te Ao Mārama, and proposed the opportunity for further *hui* in the future.

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\(^3\) Personal communication. The Hon P Hodgson *hui* with Te Ao Mārama Executive, Parliament Buildings, Wellington, 8 March 2006.
14.6 *Māramatanga* (Enlightenment)

The criterion of *māramatanga* (enlightenment) is concerned with Māori oral health promotion and education. Both the Ottawa Charter and the Jakarta Declaration apply to Māori oral health. Nevertheless it is Te Pae Māhutonga (a Māori model of health promotion) that provides a more appropriate Māori cultural framework for Māori oral health promotion. Based on the Southern Cross, Te Pae Māhutonga has six key elements for Māori health promotion: *Mauriora* (access to Te Ao Māori); *Waiora* (environmental protection); *Toiora* (healthy lifestyles); *Te Oranga* (participation in society); *Ngā Manukura* (leadership) and *Te Mana Whākahaere* (autonomy). As a consequence of Māori drive and initiative, both Māori oral health education resources and oral health promotion activities have been developed that are meaningful and relevant for Māori. The Māori oral health education resources that have been produced to date are relatively small in number, and there is a real need for the further development of innovative *oranga niho* education resources for Māori.

An important milestone in oral health was the recent referendum in Hamilton on the retention of water fluoridation. The result of a 38 per cent voter turnout was to retain fluoridation of the water supplies, with 70 per cent voting in favour. Te Ao Mārama was actively involved in the campaign from the outset. Te Ao Mārama president, Dr Albert Kewene, began with a presentation to the Hamilton City Council which was followed by a very visible public presence through promotions at local markets using give-away t-shirts, water bottles, posters and stickers\(^4\). The Māori support for this campaign would have contributed in some small way to the outcome of the referendum. Māori

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\(^{4}\) Personal communication. Kim Smith, secretary of Te Ao Mārama. 31 May 2006.
participation in such a community-wide campaign was another example of *rangatiratanga* (Māori leadership) within the dental health sector.

### 14.7 Whakapakari (Capacity Building)

The criterion of *whakapakari* (capacity building) is the key strategy for both the enhancement of existing Māori oral health providers and the establishment of new oral health services by Māori providers. This strategy requires a commitment to ongoing funding for Māori oral health providers; the development of both mobile and static clinical facilities; the development of the Māori dental health workforce; and the development of Māori oral health education resources. However, following the 2006 Budget, the Māori Party members of Parliament (Harawira 2006, Flavell 2006, Sharples 2006b) voiced their concern at the lack of ongoing funding for Māori capacity building and Māori scholarships such as Manaaki Tauira. Whilst it is premature to account for any effects or fallout from the 2006 Budget as far as Māori development is concerned, the apprehensions expressed by the Māori Party leadership remain. Despite the political machinations, Māori providers are at the cusp of *oranga niho* development following the Health Minister’s announcement of the vision for the future of child and adolescent oral health services (community-based dental services with strong linkages to Māori providers with the flexibility to extend to *whānau*/adults). This vision can be realised with the commitment of the District Health Boards to working in partnership with Māori communities and Māori providers.

### 14.8 Whakamutunga (Ending)

This thesis has demonstrated that the very essence of a Māori oral health service is based on a number of cultural norms:
1. to be Māori; to uphold mana Māori; to uphold tikanga Māori and te kawa o te marae;

2. to subscribe to Te Whare Tapa Whā as a model of health and well being which includes, te taha tinana, te taha whānau, te taha hinengaro and te taha wairua;

3. to be part of a wide network of Māori social interactions based on whānau, hapū and iwi; Māori providers and Māori organizations;

4. to base Māori health development on a framework derived from both the Articles and Principles of the Treaty of Waitangi;

5. to develop a Māori oral health workforce that is both clinically and culturally competent.

The overarching conclusion is that Māori can deliver effective oral health services for Māori and their whānau. This can be achieved through the development of appropriate relationships and partnerships between Māori, the dental health sector and District Health Boards. Developing Māori oral health services is the one key strategy for the reduction of oral health disparities and a consequent Māori health gain. An appropriate whakataūkī (proverb) to end this thesis is:

Kāore ngā niho, he aha koe?

Without teeth, what are you?
Ngā Tūtohutanga

(Recommendations)

It is recommended that:

(a) a formal dialogue be established between Te Ao Mārama (the New Zealand Māori Dental Association) and the New Zealand Dental Association with a view to enhancing relationships and partnerships between the dental health sector and Māori;

(b) a Māori Oral Health Strategy be developed by the Ministry of Health;

(c) in order to enhance the knowledge base, dental epidemiological research be undertaken, such as by conducting a national survey of adult oral health which includes robust participation by Māori;

(d) District Health Boards New Zealand investigate the rationale for establishing community based oral health services based on the model of Te Taiwhenua O Heretaunga;

(e) a national Oranga Niho Co-ordinating Group be established and funded to drive Māori oral health education and promotion activities;

(f) Te Ātiawa Dental Service and Tipu Ora Dental Service be funded to provide oral health services for whānau based on the Te Taiwhenua O Heretaunga model;
(g) The University of Otago Dental School investigate the rationale for establishing Māori community-based clinical attachments for final-year students as part of their formal undergraduate training; and

(h) Concerted efforts be made to enhance the Māori dental health workforce to include dentists, dental therapists, dental hygienists, dental technicians and dental specialists.
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Appendices

1. *Pānui*: Participant Information Sheet  
2. Participant Consent Form  
3. *Hui* and Conferences Attended  
4. *Oranga Niho* Education Resources  
5. Publications  
6. *Ngā kupu* (Glossary)
Oranga Niho: A Kaupapa Māori Review of Māori Dental Health Services

I invite you to take part in this study, which is about the issues in the development of dental health services for Māori. Oranga Niho: A Kaupapa Māori Review of Māori Dental Health Services.

What is this study about?

As Māori, we do not enjoy the same dental health status as non-Māori across all age groups. To improve dental health, Māori have been pursuing the development of dental health services. There are barriers. The aims of this study are to determine the issues in the development, implementation and operation of Māori oral health services. The study is being conducted in three areas with three dental health providers: The School of Dentistry in Dunedin, Tipu Ora in Rotorua and Te Ātiawa Dental Centre in New Plymouth. Each provider organisation has given their full support for this study.
What is involved?

To take part in an interview, kanohi-ki-te-kanohi, or as part of a small focus group. The principle investigator, John Broughton will personally interview those responsible for the development, implementation and operation of their respective Māori dental health services. The interviews will take place at a time and place to be arranged that is convenient to yourself. The interviews will be conducted based on the principles of whanaungatanga and hence may take a focus group approach rather than a specific one-to-one interview. Whānau tautoko is therefore welcome at all times.

All relevant kōrero from the interviews will transcribed and a copy sent to you for your information, consideration, additions and deletions.

All kōrero will be regarded as completely confidential to the interviewee and no person would be identifiable, unless specific permission was granted for this. Ownership of the kōrero belongs with you as interviewee and the kaitiakitanga for that kōrero rests with yourself and your dental health provider organisation.

No patients or consumers of any dental health services will be interviewed.

Deciding whether to take part in the study

You do not have to take part in this study, and if you choose not to take part, that is kei te pai. If you do agree to take part, you are free to withdraw from the study at any time without having to give a reason, and that is also kei te pai.

Will taking part cost anything?

No. Any costs associated with your participation will be covered (transport costs for example). Any costs associated with manaakitanga and āwhinatanga will be covered.
Ethical approval
This study has received approval from the Otago, Taranaki and Bay of Plenty Ethics Committees.

Study funding
I have received funding from the Health Research Council for this study which will constitute a masters thesis for the dental specialist qualification, Master in Community Dentistry.

Dissemination of study results
The dissemination of all results from the study will be by both a written report and an oral presentation back to you and your provider organisation by John Broughton as principle investigator. This will occur at a time that is convenient and appropriate for you and your provider organization. Following on from this, presentations will be made at hui, such as the Hui-A-Tau of Te Ao Mārama, The New Zealand Māori Dental Association.

As a manager, administrator or health professional associated with one of the three mentioned health services I wish to thank you for considering to participate in the interviews.

If you have any further questions about your rights as a participant in this study, you may wish to contact myself, the study supervisor, Associate Professor W.M Thomson or the Head of Department, Professor J Kieser.

Contact details for the study are:
Thank you very much. Your participation will be greatly appreciated.

Kia ora koutou

John Broughton
Name of study:

Oranga Niho: A Kaupapa Māori Review of Māori Dental Health Services

I have read and understood the pānui dated 1 October 2002 for volunteers taking part in the study designed to identify the issues involved in the establishment, implementation and operation of Māori dental health services. I have had the opportunity to discuss this study. I am satisfied with the answers that I have given.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and that is kei te pai. I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study, unless your express written consent has been given.

I have had time to consider whether to take part.

I know whom to contact if I have any questions about the study.

I will receive a copy of the results.

I……………………………………(full name) hereby consent to take part in this study.

Signature:……………………………..

Name of witness:…………………………….. Date:……………………………..

Full name of researcher: John Renata Broughton

Project explained by: John Renata Broughton

Project role: Principle Investigator

Signature:…………………………….. Date:……………………………..
Hui (Meetings and Conferences) Attended


Tipu Ora Dental Service, Final Year Dental Student Clinical Attachment, Tūn-hopū Marae, Ōhinemutu, Rotorua, 30 June – 6 July 2002.


Fifth Year Medical Students Public Health Project: Te Taiwhenua O Heretaunga Oranga Niho Programme, Wellington School of Medicine, 9 August 2002.


Evaluation of Te Taiwhenua O Heretaunga Oranga Niho Programme, Wellington School of Medicine, 6 September 2002.


Tipu Ora Dental Service, Final Year Dental Student Clinical Attachment, Tūnohopū Marae, Ōhinemuutu, Rotorua, 6 – 12 July 2003.

Tipu Ora Charitable Trust.


Mana Whenua Health Working Party.


Hui Whakapiripiri: Health Research Council of New Zealand, Māori health research *hui*, Waipapa Marae, Auckland University, Auckland, 6 – 7 November 2003.


Te Ātiawa Dental Centre, New Plymouth. Interviews and focus group, 21 November 2003.

University of Otago Dental School, Dunedin. Interviews, 2 – 4 December 2003.


*Hui* with Mrs Inez Kingi and Mr Pihopa Kingi, Dunedin, 21-22 February 2004.


Hui with Kim Smith, National Oral Health Promotion Coordinator, Dunedin, 30 March 2004


Hui with Mr Karaka Roberts, kaumātua.

Hui kaupapa: the cosmology of Te Ao Māori, Dunedin, 1 May 2004.

Hui with Mr Karaka Roberts, kaumātua,


Tipu Ora Dental Service, Final Year Dental Student Clinical Attachment, Tūnohopū Marae, Ōhinemautu, Rotorua, 4 – 10 July 2004.

Hui with Dr Chris Taylor (Te Ātiawa Dental Service), Christchurch, 27 August 2004.

X
Hui with Dr Chris Taylor, Dunedin (Te Ātiawa Dental Service), 31 August 2004.


Hui with Te Arawa kaumātua, University of Otago, Dunedin, 29 November 2004.

Te Ao Mārama, the New Zealand Māori Dental Association, Hui-A-Tau,

Hui Oranga Niho, Taranaki DHB, New Plymouth,

International Association for Dental Research (IADR) Conference, Baltimore, USA.

Mana Whenua Health Working Party, Dunedin.

The LIME Connection: CDAMS Health Curriculum Project and the Australian Indigenous Doctor’s Association (AIDA), Perth, Australia, 8-10 June 2005.
International Association of Paediatric Dentistry 20th International Congress.

J Broughton, invited speaker: "Whanaungatanga (Relationships) A key strategy for oranga niho (oral health) for tamariki Māori (Māori children) in Aotearoa/New Zealand.” Sydney, Australia, 4 November 2005.


Te Ao Mārama, the New Zealand Māori Dental Association Hui-A-Tau.

Putiki Marae, Whanganui, 10-12 February 2006.

Te Ao Mārama hui with Hon Pete Hodgson, Minister of Health, Parliament Buildings, Wellington, 8 March 2006.

Raukura Hauora O Tainui, Māori health provider. Hui oranga niho,


University of Otago Dental School Research Day.

Catalogue of oranga niho (Māori oral health) education resources

Dentistry: Information for patients

A pamphlet published by The New Zealand Dental Association circa 1990 in te reo Māori detailing the services that dentists had to offer. It only had one small print run and appeared to have a limited distribution.

Oranga Niho Oranga Kata

The term “oranga niho” first appeared as an oral health promotion slogan for Māori in 1994. The World Health Organization had declared 10 April 1994 as United Nations International Oral Health Day and the then Public Health Commission (PHC) was tasked with the responsibility for supporting the occasion. They decided to focus upon Māori oral health. J Broughton was commissioned by the PHC to help develop the strategic plan and to design the resources that would be used. The message was “oranga niho, oranga kata” (healthy teeth, healthy smile) was devised in consultation with Dunedin kaumātua, Mr Karaka Roberts. Three resources were produced for this promotion: firstly, a bilingual information pamphlet for parents (March 1994, Code 4934); secondly, and a colouring-in template of a stylised Māori figure holding a tooth brush and toothpaste which would be personalised with the child’s name (March 1994, Code 4933); and thirdly, printed balloons. These resources were distributed nationally through the Head Office of Kohanga Reo. The oral health promotion messages were about access to oral health services for pre-school children; how to care for your young child’s teeth; dietary advice (give your teeth a rest between meals); and the benefits of fluoride. Radio advertisements were also scripted and broadcast nationally on all Māori radio stations. There were three radio advertisements: the first was bilingual in both te reo Māori and English; the second
was in *te reo Māori*; and the third was in English. The scripts for these advertisements are presented on pages XIII – XVIII.

**RADIO ADVERTISEMENT No 1. (Bilingual)**

**TĀNE**

*Oranga niho, oranga kata!*

**WAHINE**

*Oranga kata, oranga niho!*

**TĀNE**

*’Ae. Healthy teeth gives you a health smile.*

**WAHINE**

*A healthy smile shows your healthy teeth.*

**TĀNE**

*Ki aha mātua o nga tamariki, tēnā koutou.*

**WAHINE**

*Did you know that when your tamariki turns two and half years of age, you can take them to your nearest school dental clinic for a dental check-up? All treatment at the school dental clinic is free.*

**TĀNE**

*Me haere koutou ngā whānau, ki te kumanu niho.*

**WAHINE**

*Go together as a whānau to your school dental clinic.*

**TĀNE**

*Be together. Smile together.*

**ORANGA NIHO**

*(Rangi: Sing a Song of Sixpence)*

*Oranga niho*

*Oranga kata*

*Ko ahau tēnei*

*Ko koe tēnā.*

*Aku niho horoi*

*Katakata hari*

*Ka nui te ora*

*Ki ahau me koe*

**TĀNE**

*Oranga niho, oranga kata.*

**WAHINE**

*Oranga kata, oranga niho.*

*Kia ora koutou katoa.*
RADIO ADVERTISEMENT No 2. (Te reo Māori)

TANIWHA  Ko ahau te taniwha kei roto i to waha!
          Homai ngā rarc. Homai te huka.
          Ah kia ora, kapai tēnā!
          Kei te kai ahau, ngā rare me te huka.
          Me te kai ahau to niho! Ahhh!

TĀNE    Ave, te niho tunga!
          He māmāe te niho tunga!

TANIWHA  Aha!
          Mēhēmea e hiahia ana koe tērā ano ētahi atu!

TĀNE    Kāore, kāore ano!
          Kei te horoi ahau i aku niho.
          Kāore nga rare! Kāore te huka.

TANIWHA  AUE! Te paraihe niho!
          Te peniho hoki!

TĀNE    Haere ra te māmāe!
          Haere ra te niho tunga!
          Haere ra te taniwha kei roto i taku waha.

TANIWHA  Kua haere ahau. Kua mate.

TĀNE    Kapai tēnā!
          Ka nui te ora o taku niho inaiane!
          Oranga niho, oranga kata!
          Oranga kata, oranga niho!
TAHI Hey Bro!
RUA Hey what?
TAHI My boy, Tarna.
RUA What's up?
TAHI He was, all last night.
RUA Was what?
TAHI Up all last night.
Hardly any sleep.
RUA Yeah?
TAHI Scratchy as one thing.
Almost drove me mad.
RUA What's the trouble?
TAHI Same old thing.
Grizzling about his teeth.
RUA Nothin' worse than a toothache Bro.
TAHI Tell me about it.
RUA And it's all your fault!
TAHI My fault?
RUA Course it's your fault.
Have you ever taken him to the school dental nurse?
TAHI Well, ah...
RUA Well have you?
I bet you haven't, Bro.
Well let me tell you that you could have taken him to the school dental nurse ever since he was two-and-a-half.
TAHI Yeah?
RUA Yeah! They check the kids teeth and do anything that needs to be done - all for free.
TAHI That right?

RUA And then the kids teeth get looked after and they don't get into those sorts of hassles.

TAHI So?

RUA So do what's right for MY nephew Bro.
Get him down to the dental nurse for regular check ups.

TAHI Okay, okay, I'm on my way.

RUA And I hope you can get some sleep now as well!

Oranga niho, oranga kata!

TAHI Healthy teeth, healthy smile.
Good one Bro!

Two further advertisements were scripted but were not used. They are included in this stock take for completeness:
RADIO ADVERTISEMENT No 4.
(Sound effects: Beep, beep, beep, blip, beep etc)

CONTROL  Ground Control to Captain Niho.
          Can you read me?

NIHO      This is Captain Niho.
          Go ahead Ground Control.

CONTROL  RED ALERT.
          You are approaching the danger zone.

NIHO      Oh No! Ground Control, does that mean...

CONTROL  Yes Captain Niho. SUGARS! SWEETS!

NIHO      We're losing power! It will destroy us!

CONTROL  Activate CODE: PREVENTION.

NIHO      CODE: PREVENTION - Fire Kotahi Toothbrush.

Sound effects: ZAP!

CONTROL  Captain Niho! Captain Niho! Do you read me?

NIHO      I read you. That was a close one.

CONTROL  Sugars and sweets are a real danger to you Niho.
          They will destroy you. Remember that.

NIHO      I've got it Control.
          All systems go. No more sweets on this trip.

CONTROL  Keep it that way Niho. Play it safe at all times.

NIHO      A-Okay Control. CAPTAIN NIHO FOR LIFE!
          TOOTH WARS TO CONTOL -
          ORANGA NIHO, ORANGA KATA!

CONTROL  ORANGO KATA, ORANGA NIHO.
RADIO ADVERTISEMENT No 4a.

(Sound effects: Beep, beep, beep, blip, beep etc)

CONTROL          Ground Control to Captain Niho.
                  Can you read me?

NIHO              This is Captain Niho.
                  Go ahead Ground Control.

CONTROL          RED ALERT. You are entering a danger zone.

NIHO              We're under attack!
                  It looks like sugars and sweets.

CONTROL          Captain Niho, take evasive action.

NIHO              It is sugar and sweets.

CONTROL          Captain Niho! Captain Niho! Do you read me?

NIHO              I read you. That was a close.

CONTROL          Sugars and sweets between meals can be a danger to you Niho.
                  They can destroy you. Remember that.

NIHO              I've got it Control.

CONTROL          Give yourself a rest between meals Niho!

NIHO              A-Okay Control.
                  ORANGA NIHO, ORANGA KATA!

CONTROL          If you like sweets, have them straight after a meal.
                  Look after your teeth. Give them a rest between meals.

NIHO              Good one Control.
                  This is Captain Niho, on a flight path to dental health!
Ka Tangara a Niho

Children's story in te reo Māori, written by Esther Tamehana and illustrated by Ali Teo. Huia Publishers, Wellington, 1996. The illustrations in this book have not been popular with many Māori who have described them\(^1\) as “ugly” and “our kids don’t look like that.” It is not known how widespread this book has been used.


Taine Randell

This resource was developed from a concept that was formulated by Pauline Koopu and Brad Betty, two final year undergraduate students at the University of Otago Dental School in 1996 and supervised by J Broughton. The resource was based on the concept of a rugby sevens tooth team with seven oral health messages carried by seven high profile sports people. A presentation was made to the Māori Health Unit of the Southern Regional Health Authority who supported the concept and agreed to provide funding for its production. However, after a full costing was done it was found to be too expensive to produce with a seven-member, seven-health-message resource. A new version was designed based on two messages using one nationally recognised Māori role model. The project was awarded the prize for the best oral health student research elective in 1996.

The resource consisted of two 18 cm cut-outs of New Zealand All Black captain, Taine Randell; one featured Taine with Tama (a boy) and the message Ma te fluoride e awhi o niho (Fluoride will protect your teeth); the other featured Taine with Hine (a girl) and the message Kei te horoi ahau i aku niho (I brush my teeth). The resource was launched by Taine Randell on 1 December 1998 at a function at the Dental School and then distributed through Otago and Southland School Dental Service. On

\(^1\) Personal communication, Te Ao Mārama Hui Ā-Tau, Ōhinemutu, 1997,
completion of their dental treatment the children were presented with one of these to take home. The idea was for the dental health message, now carried by a valued role model, to come off the posters on the dental clinic walls and to be taken home by the tamariki.

**He Kete Oranga Niho**

This is a *kete* in traditional Māori style containing a number of dental health promotion items. The *kete* is based on the mythological story of Tāne Mahuta, God of the Forest, who ascended into the heavens and brought back the three baskets of knowledge for the enlightenment of humankind. The *kete* is an icon of Māoridom that symbolises knowledge and wisdom. The resource was the result of a collaboration between the School Dental Service, HealthCare Otago, Te Waka Hauora-a-rohe, HealthCare Otago, and the Ngai Tahu Māori Health Research Unit.

The *kete* was made from cardboard but has a woven flax design photographed from an actual *kete*. The words: *He Kete Oranga Niho* (A dental health bag/kit) is printed across the front in large type. The kete contained a number of items of dental health promotion:

- A frieze of 10 cut-out 4-year old children with hands joined, each one representing a different ethnic group (Māori, Pākehā, Samoan, Niuean, Rarotongan, Tokelauan, Tongan, and Fijian) with a greeting and a dental health message (I clean my teeth) in the respective language.
- Enrolment Post Card. A postage paid postcard addressed to: The Coordinator, The School Dental Service, PO Box 5144, DUNEDIN. The caregiver supplies the name, address, date of birth, telephone number for the child to be enrolled in the School Dental Service.
• Post Card with oral health messages for parents and caregivers: “Brush your teeth at least twice a day”; “Use a fluoride toothpaste”; “Take your children to the School Dental Service”; “Healthy teeth, healthy smile”.

• A sheet of stickers featuring Hine and Tama with the message oranga niho and oranga kata emblazoned on their seat shirts.

• Toothbrush and tube of toothpaste.

• A list of School Dental Service clinics and contact phone numbers.

The resource was launched on 17 September at the Māori Health Expo held at the Dunedin Town Hall. The resource was distributed to and used by community based public health professionals or organizations who interact with whānau, especially those with parents of young children.

He Kete Oranga Niho

Oranga Tinana

Oranga Whānau

This resource was produced by Pacific Health, Whakatāne which was based on the original concept of the Kete Oranga Niho developed in Otago. The concept was extended from dental health to physical health and family health. Pacific Health also developed their own resources for inclusion in the kete including a pamphlet, Kia Tupato! Huka (Be warned! Sugar).

He Kete Oranga Niho

Well Child Tamariki Ora

This kete was developed by Waitemata Health, Auckland using the original concept of He Kete Oranga Niho that was developed in Otago. It was used by providers in the
Central North Island for oral health education activities and contained currently available oral health pamphlets, information sheets and a tooth brush.

**Te Whakapū Kōwhai Wai**

This was a 16-page booklet produced by providers in the Northland, including Hauora Whanui, with the support of the Ministry of Health in 2003. It was part of the strategy for the public campaign for the introduction of fluoridation in Whangarei. The booklet was bright, colourful, and with a clear bilingual messages about fluoridation; *Me mahi tatou mō te oranga o a tātou mokopuna, tamariki* (We need to take action on behalf of our *mokopuna* and our *tamariki*).

**Healthy Teeth/He Niho Oranga**

This was a 12-page booklet produced by Taranaki Healthcare Ltd., New Plymouth. It was written bilingually with simple diagrams and cartoon illustrations to provide information for parents and caregivers. *Ko te nui o ngā hua mō ngā tamariki e tiaki ana i o rātou niho* (Caring for your children’s teeth has many rewards). It was issued in conjunction with posters and stickers.

**Colgate Bright Smiles Bright Futures**

This was an international programme for child oral health promotion sponsored by Colgate. When the programme was introduced into New Zealand in 1998 disappointment was expressed by a number of Māori dental therapists that it was mono-cultural and only available in the English language. Te Ao Mārama, the New Zealand Māori Dental Association voiced their concern to Colgate New Zealand and offered to provide advice and support for the programme to be adapted for Māori New Zealand. Colgate responded positively to this and not only had the programme translated into *te reo Māori* but also had the colouring-in images redrawn to depict
Māori children at kohanga reo and kura kaupapa. The package in te reo Māori comprises, a story booklet, stickers, diet sheets and colouring-in templates. It was enthusiastically received by Māori school dental therapists, Māori providers, kohanga reo and kura kaupapa. Te Ao Mārama the New Zealand Māori Dental Association applauded Colgate New Zealand for their responsiveness to Māori in the presentation of this programme in New Zealand².

*Mouthguards in Rugby*

A pamphlet to promote the wearing of mouthguards in rugby and other contact sports. This was a final year dental student elective project undertaken by Raymond Te Moananui, Duncan Campbell and Rakeesh Jattan, and supervised by J Broughton in 2000. The cover of the pamphlet featured a photograph of Black Ferns captain, Farah Palmer.

*Tihei Mauri Ora: Diabetes, oral health and Māori*

A pamphlet to promote oral health based on the link between oral health and diabetes. This was a final year dental student elective project undertaken by Anna Farr and Maia Ackerman and supervised by J Broughton in 2003.

*Tihei Mauri Ora: Coronary Heart Disease, oral health and Māori.*

A pamphlet to promote oral health based on the link between oral health and Coronary Heart Disease. This was a final year dental student elective project undertaken by Faenza Bowden and Callum Dunsmore and supervised by J Broughton in 2003.

**Oranga Niho**

A poster produced by He Ora, Public Health Promotion, Auckland Healthcare Services Ltd targeting young children. It has a *waiata* for *oranga niho*:

\[
\begin{align*}
&\text{Ka ora, ka ora} \\
&\text{Ka ora ōku niho} \\
&\text{Ka ora tōku katakata} \\
&\text{Ka menemene} \\
&\text{Oke paparinga} \\
&\text{Ka ora tōku mangai} \\
&\text{Kia pai ai te kōrero Māori} \\
&\text{Tihei mauri ora!}
\end{align*}
\]

**Adolescent Oral Health Coordination Group**

A pamphlet was produced by the Adolescent Oral Health Coordination Group (Central Region) in 2003. The message was: “Free Dental Dare Till 18. Enroll With A Dentist Now!”

The pamphlet was to be distributed with an accompanying list of contracting dentists.

Whilst this resource was not Māori specific as neither Māori language nor Māori images were used, it was generic in that it pictured a mix of teenagers, male and female, some of whom could be recognised as *rangatahi* (Māori youth).

**Oranga Niho Oranga Kata**

A bilingual pamphlet produced by the Ministry of Health for parents and caregivers: *Ki ngā mātua, tēna koutou* (To parents, greetings). This was a revised edition of the original pamphlet produced in 1994. (February 2003, Code 4934). The oral health messages were:
• *Ngā niho o a koutou tamariki* (Your child’s teeth);
• *Te tiaki i ngā niho o to tamaiti* (Caring for your child’s teeth);
• *Whakangatia o niho i te kai huka waenganui i ngā wa kai* Give your teeth a rest from sugar between meals);
• *Hau-kowhai* (Fluoride).

**Te Wero: Oranga Niho**

This was a card with the slogan, *Te Wero: Oranga Niho* and the message, “Dental care is free for all *rangatahi* (13 – 17 years). Enroll now with a dentist of your choice”. The resource is based on the Māori cultural practice of a *wero* or challenge to a visiting dignitary in a formal *pōwhiri* (ritual of encounter), in which the warrior with a *taiaha* (quarterstaff) ascertains if the visitor comes as friend or foe. The contemporary image of a warrior with a *taiaha* has the added gimmick of the warrior’s hands opening up to hold a toothbrush. This was originally devised as a project during the University of Otago Dental School’s final year student clinical attachment with the Tipu Ora Charitable Trust at the Tūnōhopū Marae in Rotorua in 2002. The supervisor (J Broughton) was able to take the concept through to production and distribution with funding from the Ngāi Tahu Māori Health Research Unit of the Dunedin School of Medicine. It has been enthusiastically received by Māori providers.
Publications arising from this thesis

Refereed Journal Articles


Major Review


Refereed Conference Proceedings


### Ngā kupu Māori (Glossary)

<table>
<thead>
<tr>
<th>Māori Term</th>
<th>English Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ao Hou, Te</td>
<td>The New World, contemporary Māori society</td>
</tr>
<tr>
<td>Ao Mārama, Te</td>
<td>The World of Light</td>
</tr>
<tr>
<td>Ao Tawhito, Te</td>
<td>The Old World, pre-European Māori society</td>
</tr>
<tr>
<td>aroha</td>
<td>love, respect</td>
</tr>
<tr>
<td>hapū</td>
<td>sub-tribe; pregnant</td>
</tr>
<tr>
<td>hauora</td>
<td>health</td>
</tr>
<tr>
<td>Hine-ahu-one</td>
<td>The first woman, created by Tāne; mother of Hine-titama</td>
</tr>
<tr>
<td>Hine-nui-te-pō</td>
<td>The great lady of the night; goddess of death</td>
</tr>
<tr>
<td>Hine-titama</td>
<td>The daughter of Tāne and Hine-ahu-one</td>
</tr>
<tr>
<td>Hinengaro, te taha</td>
<td>the mental dimension</td>
</tr>
<tr>
<td>hui</td>
<td>gathering, meeting, conference</td>
</tr>
<tr>
<td>hui-ā-tau</td>
<td>annual conference</td>
</tr>
<tr>
<td>iwi</td>
<td>tribe</td>
</tr>
<tr>
<td>kaitiaki</td>
<td>guardians</td>
</tr>
<tr>
<td>katoa</td>
<td>all</td>
</tr>
<tr>
<td>kauae raro</td>
<td>mandible or upper jaw, the terrestrial realm</td>
</tr>
<tr>
<td>kauae runga</td>
<td>maxilla or upper jaw; the celestial realm</td>
</tr>
<tr>
<td>kaumātua</td>
<td>elder or elders</td>
</tr>
<tr>
<td>kaupapa</td>
<td>topic, subject, theme, principle</td>
</tr>
<tr>
<td>kawa</td>
<td>etiquette, protocol</td>
</tr>
<tr>
<td>kehua</td>
<td>ghost</td>
</tr>
<tr>
<td>kohanga reo</td>
<td>language nest; a Maori kindergarten or pre-school</td>
</tr>
<tr>
<td>kōrero</td>
<td>dialogue, speech, story, discussion</td>
</tr>
<tr>
<td>kōrero tuatahi, te</td>
<td>introduction</td>
</tr>
</tbody>
</table>

XXIX
<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>koutou</td>
<td>you (more than two people)</td>
</tr>
<tr>
<td>kuia</td>
<td>female elder or elders</td>
</tr>
<tr>
<td>kura kaupapa Māori</td>
<td>Maori immersion school</td>
</tr>
<tr>
<td>Māori</td>
<td>normal, ordinary, Indigenous People of Aotearoa.</td>
</tr>
<tr>
<td>mana</td>
<td>status, prestige</td>
</tr>
<tr>
<td>manaakitanga</td>
<td>hospitality</td>
</tr>
<tr>
<td>manuhiri</td>
<td>visitors</td>
</tr>
<tr>
<td>marae</td>
<td>ceremonial courtyard in front of a meeting house; modern usage includes all buildings within its precinct.</td>
</tr>
<tr>
<td>māramatanga</td>
<td>enlightenment</td>
</tr>
<tr>
<td>māramatanga, te</td>
<td>research principle of expanding knowledge towards light</td>
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<tr>
<td>mātsauranga</td>
<td>knowledge</td>
</tr>
<tr>
<td>matua</td>
<td>parent</td>
</tr>
<tr>
<td>mauri</td>
<td>essence of life</td>
</tr>
<tr>
<td>mihi</td>
<td>acknowledgement, greeting</td>
</tr>
<tr>
<td>mokopuna</td>
<td>grandchild, infant</td>
</tr>
<tr>
<td>ngā</td>
<td>the (plural)</td>
</tr>
<tr>
<td>niho</td>
<td>tooth, teeth</td>
</tr>
<tr>
<td>niho tunga</td>
<td>lit. tooth worm; toothache</td>
</tr>
<tr>
<td>noa</td>
<td>balance, neutrality</td>
</tr>
<tr>
<td>nui</td>
<td>big, great</td>
</tr>
<tr>
<td>oranga</td>
<td>health</td>
</tr>
<tr>
<td>oranga niho</td>
<td>dental health</td>
</tr>
<tr>
<td>Pākehā</td>
<td>New Zealanders of Anglo-Saxon origin</td>
</tr>
<tr>
<td>pakeke</td>
<td>adult</td>
</tr>
<tr>
<td>Papa-tū-ā-nuku</td>
<td>Earth Mother</td>
</tr>
<tr>
<td>pōwhiri</td>
<td>ritual of encounter; welcome ceremony</td>
</tr>
<tr>
<td>Term</td>
<td>Translation</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------------------------</td>
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<tr>
<td>pou tokomanawa</td>
<td>main support of a carved house</td>
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<tr>
<td>rangahau</td>
<td>research</td>
</tr>
<tr>
<td>rangatahi</td>
<td>youth</td>
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<tr>
<td>rangatiratanga</td>
<td>political – sovereignty, chieftainship, leadership, self-determination, self-management; individual qualities of leadership and chieftainship over a social group, a hapū or iwi.</td>
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<tr>
<td>Ranginui</td>
<td>Sky Father</td>
</tr>
<tr>
<td>reo</td>
<td>language</td>
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<tr>
<td>rūnanga</td>
<td>tribal administration headquarters</td>
</tr>
<tr>
<td>taha</td>
<td>dimension, aspect</td>
</tr>
<tr>
<td>tātaha</td>
<td>quarterstaff</td>
</tr>
<tr>
<td>tamariki</td>
<td>child, children</td>
</tr>
<tr>
<td>Tāne</td>
<td>God of the forest</td>
</tr>
<tr>
<td>tangata whenua</td>
<td>people of the land</td>
</tr>
<tr>
<td>taniwha</td>
<td>mythological creature</td>
</tr>
<tr>
<td>taonga</td>
<td>a treasured article</td>
</tr>
<tr>
<td>taonga tuku iho</td>
<td>gift of the ancestors, precious heritage</td>
</tr>
<tr>
<td>tapu</td>
<td>state of being set apart</td>
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<td>tautoko</td>
<td>support</td>
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<tr>
<td>te</td>
<td>the (singular)</td>
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<tr>
<td>tihei mauri ora</td>
<td>the sneeze of life</td>
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<td>tikanga</td>
<td>custom, method</td>
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<td>tinana</td>
<td>body</td>
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<td>tinana, te taha</td>
<td>the physical dimension</td>
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<tr>
<td>tīmatanga</td>
<td>beginning, start</td>
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<tr>
<td>tīno rangatiratanga</td>
<td>self-determination</td>
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<tr>
<td>tohunga</td>
<td>spiritual leader; expert</td>
</tr>
<tr>
<td>tūroro</td>
<td>a patient</td>
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<tr>
<td>Māori Word</td>
<td>English Translation</td>
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<tr>
<td>------------</td>
<td>---------------------</td>
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<tr>
<td>tūtohutanga</td>
<td>recommendation</td>
</tr>
<tr>
<td>waha</td>
<td>mouth</td>
</tr>
<tr>
<td>wairua</td>
<td>soul, spirit</td>
</tr>
<tr>
<td>wairua, te taha</td>
<td>the spiritual dimension</td>
</tr>
<tr>
<td>waka</td>
<td>canoe</td>
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<td>wānanga</td>
<td>Māori tertiary institution</td>
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<tr>
<td>whaiākōrero</td>
<td>oration</td>
</tr>
<tr>
<td>whakakotahitanga</td>
<td>unity</td>
</tr>
<tr>
<td>whakamā</td>
<td>shame, embarrassment, shyness</td>
</tr>
<tr>
<td>whakamutunga</td>
<td>ending, closing, conclusion</td>
</tr>
<tr>
<td>whakapapa</td>
<td>genealogy</td>
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<tr>
<td>whakapakari</td>
<td>to strengthen</td>
</tr>
<tr>
<td>whakapuakanga</td>
<td>reference</td>
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<tr>
<td>whānau</td>
<td>family, extended family, modern usage is a group with a common bond</td>
</tr>
<tr>
<td>whānau, te taha</td>
<td>the family dimension</td>
</tr>
<tr>
<td>whanaunga</td>
<td>relative</td>
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<td>whanaungatanga</td>
<td>relationships</td>
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</table>

**Whare Tapa Whā, Te** Lit. house of four dimensions or walls

<table>
<thead>
<tr>
<th>Māori Word</th>
<th>English Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>whare tapu</td>
<td>sacred house</td>
</tr>
<tr>
<td>whare tupuna</td>
<td>ancestral house</td>
</tr>
<tr>
<td>whare wānanga</td>
<td>house of learning</td>
</tr>
<tr>
<td>whenua</td>
<td>land, placenta</td>
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</tbody>
</table>

An online Māori dictionary can be accessed at [www.learningmedia.co.nz/ngata/](http://www.learningmedia.co.nz/ngata/)