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A critical Tiriti analysis of the New Zealand Cancer Control Strategy

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ABSTRACT

Objectives: *Te Tiriti o Waitangi* is foundational to health policy in Aotearoa (New Zealand). Systemic breaches of te Tiriti have contributed to enduring health inequities between Māori (the indigenous peoples of New Zealand) and other New Zealanders. There are significant inequities in cancer morbidity and mortality rates between Māori and non-Māori. With the development of a new Cancer Control Strategy underway in Aotearoa it is timely to critically review the current Strategy with a view to strengthen efforts to minimise the harm of cancer through stronger alignment to te Tiriti responsibilities.

Design: Within this paper the authors undertake a critical Tiriti analysis of the current *New Zealand Cancer Control Strategy*. This process involves interrogating the policy against the preamble, and the articles of the Māori text of te Tiriti; focussing on kāwanatanga (governance), tino Rangatiratanga (sovereignty), ōritetanga (equity) and wairuatanga (spirituality).

Results: We found that the Strategy contained little tangible connection to te Tiriti or other Māori health strategic documents. The significance of such a gap can be clearly seen in the continuing inequities of access and outcomes for Māori with cancer.

Conclusions: We recommend that future cancer control strategies in Aotearoa be developed with te Tiriti and tikanga (Māori protocols) as the central considerations. Strengthening Indigenous content in policy is likely to improve the efficacy of health policy for Indigenous peoples and reorientate health policy to address enduring health inequities.

1. Introduction

Te Tiriti o Waitangi (Māori text), negotiated in 1840, is a foundational document of the colonial state of New Zealand [1]. It reaffirms Māori tino Rangatiratanga (absolute sovereignty) to the international community as outlined in *He Wakaputanga o te Rangatiratanga o Nū Tīreni* (the United Tribes of Aotearoa Declaration of Independence). It granted the British limited kāwanatanga (governance) of their people and guaranteed Māori the same rights and privileges as British citizens and the protection of Māori mātauranga (Māori knowledge). Since as early as 1840 the Crown has consistently breached te Tiriti and Māori have resisted the colonial project of colonisation and assimilation.

The *Treaty of Waitangi* (English version), perhaps best understood as a companion document to te Tiriti, is widely reported in Government discourses to grant the British sovereignty. Under the legal doctrine of contra proferentem, the Māori text takes precedence over the English version and is the only legitimate text [2]. The Waitangi Tribunal is a permanent independent commission of inquiry set up to examine and make rulings and recommendations on claims brought by Māori related to Crown actions that breach either te Tiriti and or the Treaty. In 2014 the Waitangi Tribunal ruled that Māori have never ceded sovereignty [3].

Unfortunately New Zealand policy and legislation has not been aligned with this ruling and continues to refer to the English text and the Crown and/or Judiciary defined Treaty principles. Within the health sector the 'three P's' of participation, protection and partnership developed by the Royal Commission on Social Policy [4] are the most widely used principles and are included within the *New Zealand Public Health and Disability Act 2000* [5]. Durie [6] has frequently argued Māori pay more credence to the actual words and articles of the Māori text rather than the principles. In the recent health-focused hearing (WAI 2575) [7] the Waitangi Tribunal ruled that the three P's were reductionist, outdated and needed to be reformed.

Te Tiriti sets out the desired relationship between Māori and non-Māori and the terms and conditions of non-Māori settlement. It promised the Government would promote and protect Māori health as a taonga (a treasure). Widespread health inequities [8] between Māori and non-Māori can be seen as evidence of the failure of the health

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Table 1
Critical Tiriti Analysis indicators [11].

Preamble	Elements showing that te Tiriti is central and Māori are equal or lead parties in the policy processes.
Article 1	Mechanisms to ensure equitable Māori participation and/or leadership in setting priorities, resourcing, implementing and evaluating the policy.
Article 2	Evidence of Māori values influencing and holding authority in the policy process.
Article 3	Evidence of Māori exercising their citizenship *as* Māori in the policy.
Article 4	Acknowledgement of the importance of wairua, rongoā and wellbeing in the policy.

system to engage effectively with diverse Māori realities. But why and how does this failure occur? Starfield [9] argued that how the health system is administrated contributes to health inequities. Likewise, the Waitangi Tribunal [7] in their WAI 2575 report found

> We are faced with the prospect of whether an important – and hitherto insufficiently recognised – cause of the inequities suffered by Māori as a population group in the last two decades is the legislative and policy framework of the primary health care system itself.

In this paper we conduct a retrospective review of the *New Zealand Cancer Control Strategy* (NZCCS) [10] using Came, O'Sullivan and McCreanor's [11] critical Tiriti analysis. We seek to investigate the alignment of NZCCS with the Māori text of te Tiriti working from the position that upholding te Tiriti and Indigenous rights to health will improve Māori health outcomes. The timing of this review is deliberate to inform the new cancer control strategy currently being developed, and to contribute to the evidence available to the stage two claimants of the WAI 2575 health kaupapa enquiry.

1.1. Cancer in Aotearoa

Cancer is one of the leading causes of death in Aotearoa and affects thousands of New Zealanders every year. In 2016 alone there were 24,086 new cancer registrations [12]. Whilst cancer is a significant concern for all New Zealanders there are significant and stark inequities in incidence, mortality and impact. Overall Māori have significantly higher cancer registration rates than non-Māori, and a cancer mortality that is almost twice as high (Robson, Purdie & Cormack, 2006). Māori are disproportionately represented among preventable cancers and those where survival rates are poor [13]. Four cancers (stomach, liver, pancreas and lung) account for 46 percent of deaths in Māori compared with 27 percent of deaths in non-Māori [14]. Fewer than one in four diagnosed with one of these types of cancers will survive for five years.

Across the cancer care continuum there are substantive health inequities at each stage of diagnosis and treatment between Māori and non-Māori [15]. The focus of the NZCCS [10] was substantially on strengthening the cancer continuum of care, with stated objectives of reducing the incidence, impact and inequalities. Although there has been some improvement in recent decades, these inequities are still evident [16]. They are also a tangible demonstration of the failure of the New Zealand government to fulfil its te *Tiriti* obligations to protect and promote Māori health.

The causes of these inequities are complex. While they appear on the surface to be driven by individual level lifestyle factors such as tobacco use and obesity, it is more accurate to note that they are fuelled by uneven access to the determinants of health, racism and the legacy of colonial policies of colonisation [17]. Increasingly it has been identified that policy and more generally the administration of the health system contributes to health inequities [7], with research consistently showing Māori experiencing poorer access to health care and poorer quality of health care [18,19]. We consider that alignment between te Tiriti and health policy is a vital step towards achieving health equity for Māori.

2. Methodology

As Māori and non-Māori activist scholars, the authors engage in this critical Tiriti analysis (CTA) of the NZCCS to encourage the pursuit of health equity and Tiriti compliant health policy. We offer this critique in what we hope is a mana-enhancing way that maintains and protects the prestige and status of those involved in writing and signing off on this policy. We appreciate that a critical review does not capture the good intentions or aspirations of those involved.

This paper utilised the CTA methodology [11] to enhance efforts to eliminate health inequities and uphold te Tiriti o Waitangi. We have chosen to work with CTA as it is an innovative new methodology that has been developed specifically for application in the context of Aotearoa. In contrast with other critical policy analysis tools, it centres Indigenous realities and addresses the key elements of decision-making, authority, worldview, equity and spirituality. The approach includes a five-phase approach to conducting Tiriti analysis. Phase one involves orientation and exploring how the policy represents *te Tiriti o Waitangi*, the *Treaty of Waitangi* and the Treaty principles. Phase two is a closer examination seeking evidence of engagement with the preamble and the articles of the Māori text; kāwanatanga, tino Rangatiratanga, ōritetanga and wairuatanga. This examination considers the language used in the strategy, statements of values and intent, and descriptions of the processes followed during its development. Phase three involves conducting a determination of the extent to which the policy addresses the following five indicators developed from the Māori text (see Table 1). The fourth phase involves strengthening practice through considering evaluation and offering solutions for improving policy and policy making. The fifth phase involves Māori having a final assessment of the overall policy; this phase is undertaken following Māori protocols and will be presented in a subsequent paper.

The CTA was initially undertaken by each individual researcher, then findings were shared and discussed until a consensus was established. The collaboration among the authors enabled assumptions and biases to be challenged and new understandings reached. Methodologically, the process draws from the traditions of kaupapa Māori evaluation [20]

3. Findings

The phase one analysis shows that the NZCCS (Ministry of Health, 2003, p. 7) acknowledges the *Treaty of Waitangi* and includes a section describing its significance as the founding document of New Zealand. More specifically it references the Royal Commission on Social Policy's (1988) Treaty principles in relation to the Treaty relationship. The Treaty relationship is explained in the glossary; 'It establishes the relationship between the Crown and Māori as tangata whenua (first peoples) and requires both the Crown and Māori to act reasonably towards each other and with utmost good faith' (p72).

The findings of phases two and three are combined here to include the policy indicators within the analysis of the preamble and articles of te Tiriti.

3.1. Preamble and kāwanatanga

The Preamble of te Tiriti outlines the intent to establish a strategic

relationship between Māori and the Crown, including reaffirming Māori rangatiratanga and land ownership. Article One relates to kāwanatanga and outlines the roles and responsibilities of governance. It often pertains to decision-making about policy, its application and implementation.

The policy indicators for these two sections are

- Elements showing that te Tiriti is central and Māori are equal or lead parties in the policy processes.
- Mechanisms to ensure equitable Māori participation and/or leadership in setting priorities, resourcing, implementing and evaluating the policy.

The Strategy was developed in partnership between the Ministry of Health and the New Zealand Cancer Control Trust (p3). The NZCCS claims it '…has been designed to be consistent with Māori needs and expectation, and to enable the dual goals of Māori development and improving Māori health' (p7). The process of how Māori were involved in the design of the Strategy is not included in the document, and nor is any specific Māori individual or group noted in the acknowledgments.

However, Māori individuals from within and outside the Ministry of Health were involved in the Steering Group, the Secretariat, the expert working groups and as submitters in the development of the strategy. Although a range of consultation meetings were called a review of the NZCCS shows no structural mechanism to ensure collective Māori input into its development. The Strategy authors conceded there was 'no organised approach' (p51) for any interested party to have a say on an ongoing basis into key issues and responses.

In relation to implementation Māori are not specifically mentioned and are presumably subsumed as stakeholders within the non-government sector. This does not recognise Māori as sovereign Tiriti partners and minimises the role of Māori in defining the important matters of the '…the process to manage, monitor and review the implementation process' (p10).

3.2. Tino rangatiratanga

This article guarantees Māori absolute authority and control over taonga (treasured items), which includes hauora (health). It confirms the unfettered pursuit of Māori aspirations. The policy indicator associated with tino rangatiratanga is

- Evidence of Māori values influencing the policy processes.

The NZCCS calls for alignment with *He Korowai Oranga* [21] the Ministry's core Māori health strategy which incorporates tino rangatiratanga in its preamble. The credibility of this is compromised when within Figure 2 (p9) which locates the NZCCS in relation to other key health policy, neither *He Korowai Oranga* nor *te Tiriti o Waitangi* are named.

The NZCCS authors note the prevalence of monoculturalism (p49), of 'one size fits all' cancer services and their inadequacies. However, the Strategy lists among its aims 'reducing barriers to cancer services for those who experience them, such as Māori, Pacific peoples and the socially disadvantaged' (p6). This associates the barriers with the people who experience them and implies a top-down 'helping' approach. It does not suggest that cancer services themselves may not meet the needs of Māori. One of the principles of NZCCS is a person-centred approach that focuses on a person's total holistic wellbeing (p20). There is no attempt to align the holistic approach with the collective notion of wellbeing/whānau ora articulated in *He Korowai Oranga*. A range of Māori health models (p49 & 50) are introduced within the Strategy to inform the design and delivery of health services. The Strategy is not framed in relation to any of the Māori models introduced.

The NZCCS has a strong unacknowledged orientation to Western knowledge and evidence. For instance, Figure 1 (p4) lists the risk factors for cancer as tobacco, fruit and vegetable intake, body mass index and inactivity. This list overlooks wairuatanga, whanaungatanga (relationship building and maintaining) and mohiotanga (connectedness and understanding of the spiritual, familial and cultural realms) that are important from a mātauranga perspective [6,22].

The importance of Aotearoa based research is noted (p12) yet only a handful of Māori academics are cited in the reference list (p72-77). The importance of building Māori research capacity is noted but no detail provided. The background documents to the Strategy [23,24] follow a similar pattern of nominal engagement with Māori academics[1] .

The NZCCS frequently references a desire to improve Māori health. Māori health providers have been described as having an important role in implementing the NZCCS. The NZCCS does not however reference any kaupapa Māori interventions except rongoā (p42) (traditional Māori medicine), which is included as part of alternative medicines. No detail is provided about expected levels of investment in Māori providers or Māori health more generally.

In the absence of detail words become rhetoric. For instance, the NZCCS identifies things such as unacceptable wait times and gaps in health promotion (p11) but there is no ethnic analysis provided to articulate what this means for Māori.

3.3. Ōritetanga

This article pertains to Māori enjoying the same rights and privileges as British subjects. The policy indicator associated with this article is

- Evidence of Māori exercising their citizenship as Māori in the policy.

From a cancer control perspective ōritetanga incorporates the whole of the cancer continuum. It begins with health promotion and cancer prevention, and requires the elimination of disparities in the diagnosis, treatment and care pathways. The Strategy states its explicit focus is on reducing the incidence of cancer and achieving equitable outcomes for Māori across the spectrum of cancer control (p7). The latter is reinforced within the Strategy as a Treaty obligation (p7). The NZCCS references specific tools to provide direction about how to reduce inequities (p12).

The Strategy outlines expectations that Māori and generic service providers work to improve the acceptability and accessibility of cancer services (p47). It does not articulate how these expectations will be monitored and notes the ongoing difficulties around standardised collection of ethnicity data (p54). This represents a significant gap in the efficacy of the Strategy.

The Strategy mentions the importance of holistic health and the 'physical, social, psychological, nutritional, information and spiritual needs' (p39) of people living with and affected by cancer. Differential access to the social determinants of health are recognised in several points of the Strategy as a driver of inequitable outcome; as are differential access to quantity and quality of care. The Strategy conceded that overall cancer mortality rates for Māori are increasing over time (p17).

3.4. Wairuatanga

Wairuatanga is an expression of Māori spirituality [25,26] which cannot be separated from health nor any health policy. The policy indicator that relates to this article is:

- Acknowledgement of the importance of wairua, rongoā and

[1] Although it is important to note a Māori academic was named as a third co-author on one of the background reports.

wellbeing in the policy.

The plan purports to be founded on te *Tiriti o Waitangi* and yet there is no acknowledgement of how the NZCCS implemented wairuatanga and rongoā in the design or formation of this strategy. The 23,000 word document only specifically mentions 'wairua' three times and does not include the word 'wairuatanga' at all. Rongoā is only mentioned once and is located as a complementary alternative medicine alongside massage, meditation and Chinese medical herbs (p42). Whilst a quantitative word analysis does not fully demonstrate how these health domains were incorporated into the document there are significant disadvantages to policy development when wairuatanga and rongoā are not part of the policy architecture. The authors do acknowledge that holistic and spiritual needs are important for Māori, but the overall document does little to address the depth and scope of wairuatanga, rongoā and the related health domains of mana, tapu (sacred), mauri (life force) and whenua (land). There are also no visible author acknowledgements to tohunga wairua (wairua specialists) or tohunga rongoā (rongoā specialists). The structural silencing of tohunga is a breach of *te Tiriti o Waitangi* and further sanitises the strategy.

The NZCCS opens (pii) with a whakataukī (proverb) acknowledging the importance of people but does not directly speak of the human impact of the loss of lives to cancer or to spirituality in any substantive sense. This lack of consideration firmly frames cancer within a western-based biological and social worldview.

4. Discussion

If *te Tiriti o Waitangi* was recognised in its rightful place as a foundation document of New Zealand then the NZCCS should be firmly aligned to it. A reader should be able to identify how it engages with the intent of the preamble, and the Tiriti Articles of the Māori text; kāwanatanga, tino Rangatiratanga, ōritetanga and wairuatanga. Likewise, te Tiriti and more specifically the Articles of the Māori text, as argued by Came and Tudor [27], are potentially usefully applied within an international context. In addition they align well to the human rights obligations outlined in the *Declaration on the Rights of Indigenous Peoples* [28].

4.1. Preamble and kāwanatanga

A close read of the Strategy shows Māori are often represented as high users of the cancer care continuum but are rarely positioned as Tiriti partners with whom one needs to negotiate the sharing of power. There is no evidence within the NZCCS that Māori had more than a peripheral role in its development.

The New Zealand Government [29] was quick to minimise the landmark ruling of the Waitangi Tribunal (2014) in WAI 1040 that Ngāpuhi (a Northern tribe) never ceded sovereignty to the British Crown. Nonetheless, the ruling successfully challenges the Crown's assertion that any of the iwi (tribal nations) ceded their sovereignty. The authors maintain if Māori never ceded sovereignty, we should expect to have a Māori-led health system, particularly in the context of cancer where Māori carry the disproportionate burden of disease.

4.2. Tino rangatiratanga

Māori make up 14.9 % of the population of Aotearoa and carry a disproportionate burden of cancer [30]. The long-standing systemic inequities in cancer mortality in Aotearoa are modifiable. Data released by the Ministry of Health [31] shows in 2015/16 only 1.86 % of Vote Health was invested with Māori providers. This level of investment is inadequate [7]. The authors urge increased investment in Māori solutions drawing on both cultural and clinical leadership to advance Māori aspirations. Māori providers have a proven track record in improving health outcomes to Māori through cultural tailored programmes [32].

Reid and Robson [33] have long asserted that Māori as Tiriti partners have the right to monitor the Crown and to evaluate Crown action and inaction. This has not been addressed in the NZCCS. Jansen [34] argues the control of collective Māori health data is critical to the pursuit of Māori health. He explains; (p194) '… when we [Māori] get data and convert it into intelligence and knowledge, we must use it wisely and tactically to influence the health system to deliver better outcomes'. Since the 1990s the National Kaitiaki [Guardian] Group [35] has protected and controlled access to Māori cervical cancer information to ensure it is used to benefit Māori women and that it does not reflect negatively on Māori. We recommend a similar body to the National Kaitiaki Group be set up to protect all Māori health data.

4.3. Ōritetanga

To achieve health equity, all peoples of Aotearoa need access to the prerequisites of health [36]. The World Health Organization defined these as access to food, shelter, peace, education, income, social justice and equity. Due to the intergenerational legacies of colonisation enacted by settler governments many Māori live in circumstances that put their health at risk. Māori do not consistently have access to the prerequisites of health. In 2013 the average Māori household income was $22,500 [30] while the living wage in Aotearoa in 2018 was defined as $46,500 [37]. The NZCCS alludes to the importance of the determinants of health but offers no clear direction of how to improve access to the prerequisites.

4.4. Wairuatanga

It is well established that the main form of treatment in Aotearoa is the Western medical health system. This system privileges reductionist and biological approaches to health treatment and almost always demands objectively measured outcomes to validate efficacy [38]. Wairua is often missing from such an approach.

Māori have an overall higher cancer incidence and mortality compared to non-Māori [13]. These inequities demonstrating the physical dimensions of cancer impact are of significant concern to all New Zealanders. However, Māori have consistently argued that health is not located just in the physical body and that wairuatanga, mauri, tapu, mana, whānau and whenua are of equal importance [6]. From a policy development perspective this means that each individual who is diagnosed with cancer should be supported to access good quality holistic support. Furthermore, it means that each whānau member should also have access to these support systems. Rongoā Māori and rongoā practitioners are imperative to the cancer journey and Ministry of Health data shows that only 19 providers across the country receive direct funding [39]. Wairuatanga is a Māori determinant of health and further recognition and resourcing is critical to overall Māori health gains.

5. Conclusion

The final word belongs to Māori. The Māori authors of this article concur that the NZCCS is poorly aligned to *te Tiriti o Waitangi*. This failure to align has cascading effects in health sector design, investment decisions around cancer, service delivery and workforce development. Māori world views need to be normalised in health policy and Māori solutions made central to the pursuit of health equity and tino rangatiratanga.

Māori are sovereign Tiriti partners, so we believe further rongoā and tikanga led policy development is critical. We suggest further tikanga led policy analysis of the NZCCS and its subsequent action plans would complement this preliminary critical Tiriti analysis. Given the Waitangi Tribunal's [7] findings in the stage one WAI2575 report, this type of close analysis of policy is critical going forward. Existing checks and balances within Crown agencies are not producing policy that is effective for Māori whānau.

Independent external review seems critical at this time to strengthen health policy. We maintain the lessons outlined here from Aotearoa may also be useful for policy makers, decision-makers, academics and practitioners in other parts of the world dealing with the complexities of Indigenous health inequities and the urgent need to decolonise the health system. We hope the forthcoming cancer control plan not only *provides* rongoā but it also *is* rongoā healing some of the harm of past health policies. This can only be done if it allows wairua, mana, mauri and tapu to have a voice.

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Declaration of Competing Interest

The authors have no conflict of interest to declare.

Appendix A. Supplementary data

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References

[1] S. Healy, I. Huygens, T. Murphy, Ngāpuhi speaks, Network Waitangi Whangarei, Te Kawariki, Whangarei, New Zealand, 2012.
[2] Waitangi Tribunal, Report of The Waitangi Tribunal on The Orakei Claim (Wai-9), Department of Justice, Wellington, New Zealand, 1987.
[3] Waitangi Tribunal, Te paparahi o te raki [Wai 1040], Author., Wellington, New Zealand, 2014.
[4] Royal Commission on Social Policy, Towards a Fair and Just Society, Government Printer., Wellington, New Zealand, 1988.
[5] New Zealand Public Health and Disability Act, (2000) NZ.
[6] M. Durie, Whaiora: Māori Health Development, 2nd ed., Oxford University Press, Auckland, New Zealand, 1998.
[7] Waitangi Tribunal, Hauora: *Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry*, Waitangi Tribunal, Wellington, New Zealand, 2019.
[8] L. Marriott, D. Sim, Indicators of Inequality for Māori and Pacific People [Working Paper 09/2014], Victoria University., Wellington, New Zealand, 2014.
[9] B. Starfield, *The hidden inequity in healthcare*, Int. J. Equity Health 1 (2011) 15.
[10]] Ministry of Health, The New Zealand Cancer Control Strategy, Author, Wellington, New Zealand, 2003.
[11] Came, H., D. O'Sullivan, and T. McCreanor, *Introducing Critical Tiriti Analysis through a retrospective review of the New Zealand Primary Health Care Strategy* Ethnicities. doi:10.1177/1468796896466.
[12] New Cancer Registrations 2016, Ministry of Health, 2018 Available from: https://www.health.govt.nz/publication/new-cancer-registrations-2016.
[13] B. Robson, G. Purdie, D. Cormack, Unequal Impact: Maori and Non-Maori Cancer Statistics 1996-2001, Ministry of Health., Wellington, New Zealand, 2006.
[14] Ministry of Health, Cancer: New Registrations and Deaths 2013, editor, M.o. Health, Wellington, New Zealand, 2016.
[15] R. Lawrenson, et al., *Breast cancer inequities between Māori and non-Māori women in Aotearoa/New Zealand*, Eur. J. Cancer Care 25 (2) (2016) 225–230.
[16] Health Quality & Safety Commission, He Matapihi Ki Te Kounga O Ngā Manaakitanga Ā-Hauora O Aotearoa 2019, A Window On The Quality Of Aotearoa New Zealand's Health Care 2019, Wellington, Aotearoa New Zealand, 2019.
[17] S. Hill, et al., Indigenous inequalities in cancer: what role for healthcare? Australia New Zealand Journal of Surgery 83 (1-2) (2013) 83–86.
[18] S. Seneviratne, et al., *Treatment delay for Māori women with breast cancer in New Zealand*, Ethn. Health 20 (2) (2015) 178–193.
[19] P. Priest, et al., Determinants of ethnic inequalities in cervical Cancer survival in New Zealand, Australas. Epidemiol. (3) (2006) 69.
[20] T. Carlson, H. Moewaka Barnes, T. McCreanor, *Kaupapa Maori evaluation: a collaborative journey*, Evaluation Matters - He Take To Te Aromatawai 3 (2017) 67–99.
[21] A. King, T. Turia, He Korowai Oranga: Māori Health Strategy, Ministry of Health, Wellington, New Zealand, 2002.
[22] E. Muriwai, C. Houkamau, C. Sibley, *Culture as cure? The protective function of Māori cultural efficacy on psychological distress*, J. Psychol. 44 (2) (2015) 14–24.
[23] J. Gavin, B. Marshall, B. Cox, Progress Towards a New Zealand Cancer Control Strategy, New Zealand Cancer Control Trust, Wellington, New Zealand, 2001.
[24] J. Gavin, B. Marshall, C. Cunningham, The Development of a National Cancer Control Strategy for New Zealand, New Zealand Cancer Control Trust, Wellington, New Zealand, 2001.
[25] M. Marsden, The Woven Universe: Selected Writings of Rev Maori Marsden, Estate of Rev. Maori Marsden, New Zealand, 2003.
[26] W. Niania, et al., *Restoring mana and taking care of wairua: a story of Māori Whānau healing*, Aust. N. Z. J. Fam. Ther. 38 (1) (2017) 72–97.
[27] H. Came, K. Tudor, *Bicultural praxis: the relevance of Te Tiriti o Waitangi to health promotion internationally*, Int. J. Health Promot. Educ. (2016) 1–9.
[28] United Nations, Declaration on the Rights of Indigenous Peoples, Author, New York, NY, 2007.
[29] A. Bennett, R. Quilliam, Crown Still in Charge: Minister Chris Finlayson on Waitangi Treaty Ruling, in New Zealand Herald, (2014).
[30] Statistics New Zealand, 2013 Census Quickstas About Māori, Available from: (2013) http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-about-maori-english/education.aspx.
[31] Ministry of Health, Funding to Māori Health Providers by the Ministry of Health and District Health Boards, 2011/12 to 2015/16, Author, Wellington, New Zealand, 2017.
[32] F. Cram, K. Pipi, Determinants of Maori Provider Success: Provider Interviews Summary Report (Report No.4), Te Puni Kokiri., Wellington, New Zealand, 2001.
[33] P. Reid, B. Robson, Understanding health inequities, in: H.R. Robson B (Ed.), Hauora Māori Standards of Health IV: A Study of the Years 2000-2005, Te Rōpū Rangahau Hauora a Eru Pōmare, Wellington, New Zealand, 2007, pp. 3–11.
[34] R. Jansen, Indigenous data sovereignty: a Māori health perspective, in: T. Kukutai, J. Taylor (Eds.), Indigenous Data Sovereignty: Towards an Agenda, Australia University Press, Canberra, Australia, 2016, pp. 193–211.
[35] Ministry of Health, National Kaitiaki Group, Available from: (2018) https://www.health.govt.nz/our-work/populations/maori-health/national-kaitiaki-group.
[36] WHO, Ottawa charter for health promotion, Proceedings of the 1st International Conference on Health Promotion, World Health Organization: Ottawa, Canada, 1986.
[37] Living Wage Aotearoa New Zealand, 2017 Living Wage Rate: $20.20, [cited 2018 14 February]; Available from: (2017) https://d3n8a8pro7vhmx.cloudfront.net/nzlivingwage/pages/263/attachments/original/1487586293/The_Living_Wage_Rate_Announcement_2017_alternativev2.pdf?1487586293.
[38] G. Mark, J. Koea, Identifying Rongoā Māori Healing and Medical Health Collaboration Issues: A Thematic Synthesis Review, Health Research Council: Auckland, New Zealand, 2019.
[39] Ministry of Health, Rongoā Māori: Traditional Māori Healing, [cited 2019 28 October]; Available from: (2019) https://www.health.govt.nz/our-work/populations/maori-health/rongoa-maori-traditional-maori-healing.