Research project: Hauora Kotahitanga: a PhD in Community, University of Auckland, submitted 2010
The purpose of the research: was to add the knowledge and experiences of five hauora Maori communities to the indigenous health development literature. The research explored how the hauora Maori communities used matauranga and tikanga Maori as constructive engagement mechanisms for practicing co-operative co-existence with non-Maori through creating community unique health models. It explored how their health models resulted in Maori and non-Maori living together differently through health developments in their communities. It also conceptualised these experiences as indigeneity based models for indigenous and non-indigenous peoples to co-operatively co-exist through living together differently.
The methodology: used in this research draws on the teachings of three Maori scholars who have contributed to the fields of Maori health development, indigeneity, and matauranga Maori. Mason Durie is a respected researcher in Maori and indigenous health developments (Durie, 2001, 2003, 2005). Durie explains indigeneity as "a system of knowledge based on a state of fusion between indigenous peoples and their accustomed environments" (2005, p. 137). Durie's concept of indigeneity is used in this inquiry to frame 'how' indigeneity was practiced by Maori through the tikanga Maori methodologies used by Maori to create a "state of fusion" between "a system of knowledge", in this case matauranga Maori knowledge, and "their accustomed environments", in this case non-Maori communities. Maaka and Fleras' (2005) concept of indigeneity based constructive engagements is used to frame 'why' the engagements occurred. Specifically, the Maaka and Fleras concept is used to identify why the constructive engagements that resulted in hauora Maori models might provide models for co-operative co-existence through indigenous and non-indigenous peoples living together differently. The final frame of the inquiry is to explain what Maori elements underpin the constructive engagements studied, and the teachings of Maori Marsden (2003) guide understanding of the indigenous knowledge, or 'matauranga'. Maori have their own perception of their world, how it is ordered, and the relationships that exist between the spiritual world, the natural world, and the peoples (Marsden, 1975, 2003; Marsden & Henare, 1992). This Maori world is contemporaneously referred to as 'te ao Maori' (Durie, 2005). Marsden explains there is a difference between 'knowledge' and 'knowing' in the world of Maori, te ao Maori. "Knowledge (matauranga) is different from knowing (mohio) … knowledge belongs to the head and knowing belongs to the heart. When a person understands both in the mind and in the spirit, then it is said that the person truly 'knows' (mohio)" (Marsden, 2003, p.79). It is the matauranga Maori that has evolved into models for delivery of indigeneity based health services into indigenous and non-indigenous communities, which are the basis of this inquiry. The examination of the matauranga Maori, and the tikanga Maori through which matauranga Maori was practiced in health developments from the 1990s, is augmented through an analysis of the matauranga Maori found within Crown Maori health policies in the same period.

The Maori community studied is within the Ngati Whatua region. The research has been designed to include, and treat equitably, the matauranga and tikanga Maori of the non-Ngati Whatua affiliated organisations studied, to comply with Ngati Whatua tikanga, as the equitable treatment of the mana and tapu of other iwi or hapu is reiterated in the Ngati Whatua health whakatauki: "***Kia mau ki te mana o te whanau, te hapu me te iwi:*** *The mana and tapu of other iwi or hapu must also be observed."* The thesis design incorporates this whakatauki by examining two Ngati Whatua affiliated health service providers (Te Ha and Orakei) and two non-Ngati Whatua affiliated health service providers (Te Puna and Te Roopu Taurima).

Traditionally, Maori knowledge is passed through oral transmission, or storytelling. The karere was traditionally the talking newspaper who went from village to village disseminating knowledge. The villagers would gather and hear the same story from the karere, however the layers of knowledge, lore and information imbued in each story, would resonate differently with each of the audience members, dependent upon their knowledge of the lore and information being imparted. The karere was therefore similar to the troubadours or courtesans of old Europe; a walking encyclopaedia of knowledge and lore, delivered within the socio-cultural-political moment through stories purposefully crafted for the audience. Thus, a narrative, or story-telling approach, has been adopted through the design of the research process. Rather than interviewing key informants, the research data was collected primarily by listening to how the key informants from the organisations explained the stories of the creation and implementation of their matauranga and tikanga Maori into their hauora Maori models. Examples of the stories gathered under the narrative approach, through participant-observation include: kaumatua and kuia explanations to new staff and board members of the matauranga and tikanga of their hauora Maori models; management presentations to inter-sectoral agencies involved in the organisations service delivery or co-management of service consumers; management and board presentations to iwi, health funders, social policy funders, government representatives; staff discussions of services to new staff in training; and kaimahi of the organisations presenting at health conferences.

Some of the findings - The Kaimahi Model: New directions in health development often occur at the political and policy level of government, and then work their way down into the health systems through implementation. Two of the hauora models created in the 1990s grew from staff social club initiatives, one within a Maori primary health organisation, Te Puna Hauora, and one that began within a non-Maori residential disability services organisation where the staff then separated from the non-Maori organisation to form a Maori organisation, Te Roopu Taurima. In this way, the kaimahi drove aspects of the matauranga Maori knowledge and tikanga Maori methodologies from the community up and into the organisations development.

The first example is Te Puna Hauora, whose I-MAP model was initially a staff and community initiative to constructively engage with and define the community needs, particularly for whanau in crisis situations. They came up with a plan, but were frustrated by the time it was taking to deal with bureaucracy and red tape to get funding in order to deliver their ideas. They decided to use their social club fund to cover the costs of delivering the service. The whanau outcomes through the new service delivery were compelling, with case studies of positive whanau outcomes presented to external organisations to seek funding to develop the services into a coherent delivery model. A number of external organisations all gave small amounts of money to pursue the development of a community based model. This was problematic however for the staff of Te Puna Hauora because the reporting mechanisms required for a large number of small value contracts meant that little of the money was able to be used on actual service delivery. However, the community integrative nature of the model was able to be evidenced by the involvement of a large number of community funding organisations in getting the model produced into a fundable format. The large number of small funding contracts to get this service started provided a greater range of constructive engagements with other community organisations than would have been possible through one funder. This was an unexpected bonus of the erratic funding. The variety of constructive engagements that were undertaken to organise funding, resourcing and assistance for the new service resulted in NGOs and community organisations such as Housing New Zealand, the Budgeting Service, and legal aid services beginning to deliver workshops and services on a regular basis at the Te Puna Hauora building for whanau who were in what was eventually called the I-MAP service. Effectively, a one stop shop for health and social needs evolved out of the multiple-agency approach that had in part been facilitated by the search for funds to run the service.

The health funding authority did not have a contracting mechanism for such a combination of 'social' services with health services, which was one of the defining elements of the Te Puna Hauora I-MAP model. Funding for health services did not include social interventions under the Health Funding Authority in the 1990s. There were health promotion contracts being delivered through Maori health organisations under public health funding at this point, but the I-MAP model did not fit well either with these contracts, or with the primary health contracts already being delivered at Te Puna Hauora. The first funding to come from the Ministry of Health was through the Maori Provider Development Scheme. Te Puna Hauora was initially only able to get funding to 'create a best practice model', funding which they also used to continue service delivery. However because the funding to 'create a best practice model' was in effect being used on service delivery, the staff and the community came together to ensure that that contract requirements of producing and documenting a model were achieved. One of the whanau participants of the I-MAP service, a person who had arrived under the UN refugee program from an African country, volunteered to assist in the desk-top publishing of diagrams and graphics to go with the presentation accompanying the model. His case study diagrams are at appendix 3 of the thesis, and were used to present the model to the Ministry of Health and the Ministry of Maori Development when Te Puna Hauora sought their assistance in further developing the services. They were also used to present the model to the New Zealand Prime Minister in 2001. The result of this collaborative effort between the staff, whanau and community of the service, and health and community development organisations, was a model for co-operative co-existence that had been designed by the 'workers and patients', or kaimahi and whanau, which was then developed by the 'management and community' or kaimahi and whanau, and then funded by state health and social service agencies, and community donations and resources.

The second example of a Maori-driven self determination model being transitioned into a community-driven self-determination model, comes from the staff social club of Mangere Hospital and Mangere St John's home services. One third of the patients of these services were Maori (Tenari, 2009). From the 1990s government policy moved towards community, rather than institutional care, for people with intellectual disabilities, and Mangere Hospital and Mangere St John's services were devolved out into the community to Spectrum Care. The Maori staff social club of Mangere Hospital and Mangere St John's home services had a strong focus on facilitating tikanga Maori knowledge amongst the staff, who formed a kapa haka group, and learned waiata, karakia, and taniko weaving, under the guidance of kaumatua kuia (Tenari, 2009). This evolved into Maori services for the patients being set up for Mangere Hospital and Mangere St John's, by participants from the Maori staff social club. When

Tuila Tenari was asked to investigate how appropriate services for Maori could be created in the devolution process to the community, she and the Maori team followed tikanga and consulted the whanau, hapu and iwi of the patients (Tenari, 2009). The results of these constructive engagements with the Maori intellectual disability community, and the corporate bodies for intellectual disability services management in New Zealand, was that the Maori staff social club Te Roopu Taurima o Manukau was established as a charitable trust to facilitate Maori intellectual disability service development: services that would be driven by board members who included whanau of the peoples living in the services (Stacey, 2009, Tenari, 2009).

Both the Te Puna Hauora and Te Roopu Taurima examples evolved through the impetus of Maori health workers to develop and deliver 'by Maori for Maori' programmes, and evolved into 'by Maori for all' programmes developed and delivered by Maori and non-Maori health workers. They are conceptualised here as a 'Kaimahi Model"

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