A Journey for Māori and Gout: Putting Your Best Foot Forward

by

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(Indigenous Studies)

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Declaration

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Betty-Lou Iwikau

Date: December 2012

Contents

GLOSSARY

Kupu Māori	**English**
Atua	God/deity
Hoa Haere	Companion
Hapu	Sub-tribe
Haumiatiketike	God of the uncultivated plants
Hinenui Te Po	Goddess of Death
Hongi	Formal engagement of pressing of noses
Hui	Meeting
Io	Supreme God
Iwi	Tribal affiliations
Kāawai Tipuna	Direct ancestor
Kapu Ti	Refreshments
Karakia	Prayer, incantations
Kaumatua	Male elder
Kaupapa	Topic
Kaupapa Māori	Māori philosophy, conceptualisation of Maori knowledge
Korero	Discussions, to speak
Kuia	Female elder
Ma Ta Waka	Confederation of Tribal Canoes
Mana	Prestige
Manāki	Hospitality, Care for others
Marae	Ceremonial courtyard, village plaza
Matauranga Māori	Māori knowledge
Mauri	Life-force
Mihi	Formal greeting
Noa	Restoring balance
Papakainga	Homeland
Papatuanuku	Earth mother
Purakau	Traditional stories/Ballads
Ranginui	Sky-father
Rongomatane	God of peace/cultivated foods
Takepu	Principle positioning
Tangaroa	God of the Sea
Tapu	Sacred
Tawhirimatea	God of the Winds
Tawhito	Old times, of great age
Te Aka	The Vine

Te Ao Māori	Māori worldview
Te Ao Marama	World of Light
Te Ara Piki Ki Rangituhaha	The Pathway in the journey of discovery
Te Ata	Morning
Te Kore	The Abyss
Te Kore I Ai	The void with nothing in union
Te Kore Te Rawea	The void in which nothing could be felt
Te Kore Te Whiwhia	Void in which nothing could be obtained
Te Kore Te Wiwia	The space without boundaries
Te More	Taproot
Te Po	Voids of night, darkness
Te Po Kerekere	The Intense Night
Te Po Namunamu-Ki-Taiao	The Night of Seeking The Passage
Te Po Nui	The Great night
Te Po Roa	The Long Night
Te Po Tangotango	The Intensely Dark Night
Te Po Uriuri	The Deep Dark Evolvement
Te Po Whawha	The Night of Feelings
Te Pu	Root cause
Te Tipuranga	The Growth
Te Weu	Rootlets
Tikanga	Protocols
Tipuna	Ancestor
Tumatauenga	God of War
Waiata Moteatea	Traditional Maori songs
Taha Wairua	Spirit side
Wananga	Place of learning
Whakamā	Inner consciousness, facial/body expression
Whakanoa	Restoring Balance
Whakapapa	Genealogy
Whānau	Family
Whānau Whānui	Extended family
Whānaungatanga	Interrelationships, maintaining family connections, extended family connections

Abstract

Evidence of health disparities between Māori and non-Māori are recorded in New Zealand's colonial history, Ministry of Health (2010a:1). Such differences suggest complex components that are associated with socio-economic and lifestyle factors, availability of health care and discrimination. Improving access to health services in New Zealand is critical to addressing health disparities and according to Robson B, Harris R. (Eds) (2007) their evidence suggests that Māori are less likely to access health services than non-Māori. A number of other barriers have been identified for Māori not seeking healthcare services, and the majority of these were related to the health system not dealing appropriately with cultural issues. Furthermore, Māori men score worst of all in New Zealand groups on a number of health indices, and have some of the poorest health records in the world in some areas aspects of health, disease and mortality, Malcolm, L. (1996, 109: 356-358). Although there are many health related conditions for Māori that still require further investigation, this area of research will focus on Gout.

The Māori Gout Action Group in Counties Manukau District Health Board, Auckland New Zealand, published an article "Debunking the myths to provide 21st Century management of gout," New Zealand Medical Journal (2008) provided an overview of complex issues relating to gout in South Auckland, New Zealand. This article indicated for many Māori whānau, gout was a common occurrence and some whānau did not talk openly about it, although it is readily treatable and can be prevented. This has led to a tolerance of pain and disability and low expectations of treatment with significant impact on quality of life. It is suggested that better methods are required to counteract gout in people of Māori culture. If untreated, gout will form a large accumulation of uric acid crystals in the joints and soft tissues known as tophi *or* bone erosion, permanent disability, Dalbeth, N. et al., (2007) as well as breaking down to form ulcers which lead to systemic infection, Kumar, S., Gow, P. (2002). As a result for Māori it exacts a significant health and economic burden.

This study examines a range of issues to improve access for Māori into health care services through the development of a *whakapapa* (genealogy) model about gout. It demonstrates the effectiveness of a dual paradigm approach using Māori bodies of knowledge framed by a *whakapapa* (genealogy) paradigm of *Te Kore* (abyss), *Te Po* (voids of darkness), and *Te Ao Māori* (world of light). The Māori human development framework tracks stages of growth and development within the *whakapapa* (genealogy) paradigm framed by *Te Pu* (the root), *Te Weu* (the rootlets), *Te More* (the taproot), *Te Aka* (the vine) and *Te Tipuranga* (the growth). It aligns with Māori and Western bodies of knowledge through the clinical process about gout and intertwines

the two schools of thought that are seen to improve access to and quality of health care for Māori. The dual paradigm approach contextualised the transformation of learning through one-to-one whānau (participants) interviews and *Wānanga*.

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Teena teena,
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"Mehemea karekau ana he whakakitenga ka mate te iwi," (King Tawhaio).

Ko Tainui tooku waka
Ko Maungatautari tooku maunga
Ko Waihau tooku Awa
Ko Pikitu, Ko Ngatira, Ko Tarakena, Ko Ruapeka ooku marae
Ko Ngati Ahuru, Ngati Wewehi, Ngati Tukorehe ooku haapu
Ko Ngati Raukawa kaokao roa patetere
Ko Betty-Lou Iwikau tooku ingoa

Teenaa koutou anoo hoki raa.

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Finally I would like to thank the Creator in whom all things are possible.

Karakia Watea

Tenei au Tenei au , ko te hokai nei o taku tapu wai
Ko te hokai nuku ko te hokai rangi
Ko te hokai a to tupuna a Tanenuiarangi
I pikitia ai ki nga Rangituhaha ki te tihi o manono
I rokohina atu ra ko Io Matua Kore anake
I riro ai nga kete o te wananga
Ko te kete Tu-a-uri
Ko te kete Tu-atea
Ko te kete Aronui
Ka tiritiri au Ka poupoua Kia Papatuanuku
Ka puta te ira tangata ki te wheiao
Ki te Ao Marama!

Here am I, here am I, here am I quickly moving by
The power of my karakia for swift movement
Swiftly moving over the earth
Swiftly moving through the heavens,
The swift movement of your ancestor Tanenuiarangi
Who climbed up to the isolated heavens,
The summit of Manono, and there found Io-the-parentless alone
He brought back down the baskets of knowledge,
The basket named Tuauri,
The basket named Tuaatea
The basket named Aronui.
Portioned out and planted in Mother Earth,
The life principle of human beings comes forth into the dawn,
Into the world of light.

Chapter One

A Journey: Gout and Me

After the birth of my baby girl on the 18th April 2008 and knowing she was to be our last, my attention turned again to complete a PhD which in my mind I needed to do. At that time many ideas on what to write about included a passion to undertake research on Māori women. Cervical screening was a possibility based on a high population of Māori women and their experiences in having limited access to appropriate services. Another idea was to examine the power of music within the context of social work practise as another tool or resource of intervention to assist people to work through life challenges and problems.

In 2009, I came to an understanding that I needed to seek spiritual guidance using karakia (prayer) based on teachings and learning of my tīpuna/elders who were steeped in Catholicism. What I experienced from this encounter was the need to consider the impact of disease on Māori population, hence the emergence of the discussion on gout. I was comforted in my mind and heart that my tīpuna were guiding me in this decision. It was an accepted fact that karakia would provide the pathway in this body of research. It was not without a lot of soul searching and anxiety to come to this point of the study.

In 2010, I met with graduate staff of Te Whare Wānanga O Awanuiarangi to discuss angles, insights and knowledge that this research could contribute to about gout and its impact on Māori. I then enrolled at Te Whare Wānanga O Awanuiarangi as a PhD student in 2011.

An essential element to this thesis is the framework Te Ara Piki ki Rangituhaha that I had developed as a student while studying a Diploma in Adult Teaching with Te Wānanga O Aotearoa. This framework provided for me a sense of purpose, meaning and direction therefore in my view bringing a form of order to my life. It was delivered to social worker students in their final year of the Bachelor of Biculturalism Social Work Practice at the same wananga. The insights gained have led me to undertake research on Gout.[1]

The Framework: Te Ara Piki ki Rangituhaha

This is what I deem to be the beginning of a transformation process that provided meaning to my chosen pathway, and in this instance my kaupapa (topic). It is the pathway of purpose, destiny and discovering who I am. Piki ki (journey to) is how I choose to describe the process for this pathway. Piki ki is to grow the seed planted within Te Ara (the pathway) therefore, providing a deeper meaning of understanding to my journey using past, present, and future experiences to ensure that my journey had purpose. Fashioned by expert hands the

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[1] Toroa-te-Nukuroa, Volume VI, 2011. Whānau Transformation through Wānanga Education, Te Wānanga O Aotearoa.

pathway provides clarity toward discovery of enlightenment. Rangituhaha (discovery/destiny) a space where one has mastered their pathway of ‘knowing’ or new knowledge. For me this is achievement, the sense of making it through challenges and other such barriers.

Te Ara (pathway)

The real leader has no need to lead as he/she is content to point the way

(Walsh, N.D. 1995).

Te Ara (pathway) represents a transformative dynamic of the legacies passed down from my tīpuna, the stories that lie in the profoundly empowering recognition that one is not only the main character but also the author of the story. Central to the concept of transformative dynamic is the matter of gaining a more critical and empowered perspective of one’s life journey through telling and interpreting one’s story, (Kenyon, G.M., Randall, R.L. 1997).

The emphasis on the leader is to empower individuals to believe, to reshape their thinking that they can make a difference in their lives upon others. My ‘knowing’ of Te Ara is a place for me where a series of transformative processes occur within my taha wairua (spiritual being), taha hinengaro (mental ability), taha tinana (physical being) me taha whānau (family connections). These concepts must be considered as a whole in order for the transformative process to occur. My ‘knowing’ of these concepts is represented with a rhythm and a heartbeat that can occur when people engage.

It is a place where rediscovering and reconfirming who I am in the course of new learning, begins. Such learning emerges as the time to move to the next stage or pathway of transformation. I have learnt how to go from one stage or pathway to the next which I call the Key. The Key assists me to unlock the door to this pathway of learning and gain entry into Piki ki, but what is this key?

The KEY IS ME. I know that I am responsible for the key, I have obligations, I am accountable and require of myself to be transparent in my learning to the end of my journey.

I AM THE KEY which is within me. It is part of me and I have now discovered over many years of searching for someone to guide me that I already had someone to show me this pathway and that was me. I was the one who unlocked this door to my pathway of learning and people sharing this pathway were there to support. The uncertainty I thought I had, was no longer present, I realised I misread and misinterpreted the response back from my tīpuna. I actually created the doubt and what I wanted to believe that my kaupapa (topic) should be. Whilst I knew this, I still needed to learn through this experience and continued therefore unlocking the door to research on Gout.

Piki ki (journey to)

A true teacher is not the one with the most knowledge, but one who causes the most others to have knowledge[2]

Narrative fosters learning as a transformative process a tool that is believable, memorable and entertaining (Neuhauser, P.C. 1993). It instils in me and my whānau our valued contribution and lived experiences. The belief stems from the fact that stories deal with human or human-like experiences that we tend to perceive as an authentic and credible source of knowledge. The basis of the story, the specific situation, the small details, the vivid images of human experience that evoke a fuller response than does a simple statement of fact. The stories then provide detail of raw material for both cognitive appreciation and affective response to the experience of another person.

In my 'knowing' in Piki ki is the knowledge that I opened this pathway, I opened this door and there is a reason I am in this position at this time, in this moment. Instilled in me I know I am responsible for the key, I have obligations to the key and I am accountable for the key. Who is the key? I am the key. This journey has meaning for me and it is the learning of this experience because everything in life, I believe has a purpose. As I was taking this journey and reading what I had written, how could I have doubted the teachings and learning of my tīpuna. I believe that through the power of pray it was answered. But I still needed to continue to the final level of the framework that is modelled within this thesis.

Rangituhaha (discovery/destiny)

A true master is not the one with the most students, but one who creates the most Master.[3]

The pathway of learning can be transformed and Te Ara (the pathway) and Piki ki (journey to) contextualises this meaning, purpose and understanding, through Rangituhaha. It is about the quality of masters that sit within Rangituhaha, forever we will teach to create masters that transform our learning towards caring for others and in doing so I cease to become your master because you are my equal.

What would I learn - if you suggest the concept of karakia? My faith should never have been questioned as there is a bigger picture than what I wanted to believe and I believe it is my destiny to serve the people. This kaupapa on gout has been gifted to me and that is why the title was 'my journey: gout and me.' It had taken me two years to fully accept the kaupapa on gout as the journey undertaken, has been amazing, fruitful and very rewarding.

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[2] Ibid

[3] Ibid

I believe this thesis is as close to what my tīpuna gave me to write on and represents thirty people who identify as Māori and who suffer from gout alongside twenty of their whānau support. A personal experience of gout has been indirect, hence the use of Te Ara Piki ki Rangituhaha. This is my welcome to *Te Ara Piki ki "Rangituhaha* (the pathway in the journey of discovery/destiny) for all in this situation.

An Overview

The 'Gout Capital of the World' was a description given to Counties Manukau, Auckland, New Zealand, by a Doctor of Rheumatology gout specialist from the United Kingdom undertaking qualitative research into why gout appeared to be such a problem in South Auckland, New Zealand, (Lindsay, K. 2007:9). The stories revealed by this qualitative research of working age men severely incapacitated by a condition well-recognised in their families, and a condition that should be readily treatable. In South Auckland, New Zealand, there has been increasing numbers of reported cases of gout among Māori; nine point three percent (9.3%), of Māori men have gout, it is likely that these figures significantly underestimate the true burden of this disease, as anecdotal evidence suggests that whānau members infrequently share acute pain relieving medications for gout, so they may not present to medical care to have a formal diagnosis. Furthermore, New Zealand studies conducted in 2005, suggest gout is also frequently linked to other priority conditions such as cardiovascular disease, diabetes and obesity, (Baker, J.K., et. 2005:118-816-26., Krishnan, E., et. 2005:54:2688-96).

As a result of growing concern within Counties Manukau a Māori Action Group was established. The group had identified five myths that they believe may be undermining best practice by the medical community, patients and their whānau, and perpetuating under-treatment of gout:

1. Gout is a relatively uncommon and minor condition compared to other priority issues that need attention;
2. Gout doesn't consume secondary care resources;
3. People who have gout bring it on themselves by drinking too much and eating the wrong food;
4. Gout is a 'normal part of life and you just put up with it; and
5. Medications for Gout should be taken for acute attacks only.

Although all five myths are important to mention, myths 3, 4, and 5 will be selected and form discussion points in Chapter 6 Shades of Whakamā to critically analysis 'the lack of understanding about gout among Māori and demonstrating the many shades of *Whakamā* (inner consciousness, facial/body expressions) as a positive *hoa haere* (companion). To provide some insight to the depth and breadth of *Whakamā* (inner consciousness, facial/body expressions) as a cultural barrier among Māori, for myth 3, while acknowledged that attention is an important aspect of gout management, many Māori patients do not 'overindulge' in alcohol beverages and seafood. This perception in many ways becomes barriers for those who suffer from gout and whānau placing blame and shame on them; myth 4 whānau tend not to talk about gout, *Whakamā* (change in facial/body appearance, inner-consciousness) is common because of the perception that the cause of gout is alcohol and overeating; myth 5 many Māori who suffer from gout do share their medication and do not access health services such as their GP for help. Equipping whānau with education that there are medications that can relieve the acute pain of gout. More important is that gout medication combined with lifestyle changes can prevent recurrent attacks and long term disability.

A Contribution to New Knowledge

This thesis seeks to examine the implementation of a whakapapa based model as an analytical framework to measure a paradigm shift from a medical model perspective of treating gout symptoms to a *Te Ao Māori* (Māori worldview) thinking on the disease. The study will also explore *whakapapa* (genealogy) processes of the medical model for Gout, its medical intervention and contra indicators. It is my intention to develop a *Te Ao Māori* (Māori worldview) cultural framework model to addressing a perceived lack of understanding about gout by developing a whakapapa model on Gout. An attempt is not been made for a cure but rather provide better understanding of managing gout through *Te Ao Māori* (Māori worldview) knowledge, reasoning and rationale. Bodies of knowledge specific to cultural groupings allow linguistic compatibility, driven by cultural frameworks and methodologies and framed by philosophical underpinnings respond more effectively than the medical model on its own. This is supported by the Health Waikato (2001) report that states that to improve the health of Māori, it is important to consider cultural factors such as Māori worldview and reality, importance of Māori language and customs to Māori and their healthcare, and the impact that whānau can have in influencing individual attitudes and behaviours.

Expectations of Research Undertaken

There are a number of overarching aims to this research; how the lack of understanding about gout has created unhelpful myths and contributed to Māori not accessing health care services for treatment and education. Whakamā (inner consciousness, facial/body expressions) will be a guiding principle in unearthing the myths towards cultural interventions and cultural reasoning. The implementation of a whakapapa model as an analytical framework to measure a paradigm shift from a medical model perspective of treating gout symptoms, to *Te Ao Māori* (Māori worldview) thinking on the disease.

Critical questions to be addressed

This thesis also seeks to address questions pertaining to the research that will assist in gathering the information required have been informed by the gaps provided through the literature review.

1. How would a paradigm shift from medical model framework of thinking to a Te Ao Māori framework of thinking improve Māori health?

2. How would the dissemination of a Te Ao Māori framework of thinking influence Māori communities' engaging better with health services?

3. How would a cultural model, its interventions and indicators for gout support the medical community and best practice?

This research examines to understand how a *whakapapa* (genealogy) model about gout serves as a means to measure a paradigm shift from a medical model perspective of treating gout symptoms to *Te Ao Māori* (Māori worldview) thinking on the disease, and most importantly whether a *whakapapa* (genealogy) model will make a significant contribution to the lives of those who suffer from gout, their whānau (family) and Māori communities. The *whakapapa* (genealogy) model about gout will describe how relationships connect with each other, rituals of engagement within these relationships, the meta-cognitive process of thinking that has contributed to the unhelpful myths and its tensions. *Whakamā* (inner consciousness, facial/body expression), will illustrate the depth and breadth of these relationships and its impacts on these relationships as enablers and barriers.

In chapter two an examination of the health status of Māori in New Zealand and the significant inequalities that exist with Māori and non-Māori is undertaken. The reasons for health inequalities are complex and generally beyond the control of the groups most affected. This chapter further explores the impacts of colonisation and health, examines the complexities of health inequalities in New Zealand between Māori and non-Māori populations.

The prevalence of gout among Māori is the focus of chapter three. *Whakapapa* (genealogy) signifies a sequential order of events where history unfolds such as health. It is through whakapapa (genealogy) that ways of knowing when working with illnesses such as gout unfolds. The medical model continues this process of whakapapa (genealogy) through its history and examining the clinical process about gout. A picture of the health status of all New Zealanders, indicator Māori have poorer health and outcomes compared to non-Māori and are more likely to be exposed to risk factors for poor health, (Ministry of Health, 20120:3). Finally a systems thinking approach that demonstrates a dual paradigm of Māori and Western bodies of knowledge as hoa haere (companions) sharing equal space is investigated.

In chapter four a model discussing a dual paradigm methodological approach to this research is discussed. Action Research is seen as a powerful tool[4] for change and improvement in health services for Māori people when utilised within an appropriate framework. The research model - dual paradigm is an integrated approach embracing Māori and Western paradigms of thinking when supporting Māori with gout that illustrates this convergence in its use of Kaupapa Māori Research methods in its efforts to improve the health and well-being of Māori within South Auckland communities. It outlines the research processes and outcomes obtained through the application using a dual paradigm approach to understand Māori pathways and disablers when accessing health services for the disease gout. The research examines dual paradigm of Māori and Western bodies of knowledge as hoa haere (companions) sharing equal space.

Chapter five provides an overlay of the dual paradigm kaupapa Māori/Clinical process about gout. It examines a dual paradigm approach using kaupapa Māori (Māori worldview) and clinical process about gout, framed by whakapapa (genealogy) epistemology. The first section will explore whakapapa framework using Te Kore (the abyss), Te Po (voids of darkness) and Te Ao Marama (world of light) This framework will assist in describing behaviours and characteristics of individuals experiencing gout, (Buck, T.H. 1949). Māori human development model Te Pu (root cause), Te Weu (rootlets), Te More (taproot), Te Aka (the vine) and Te Tipuranga (growth) will track stages of growth and development within the whakapapa paradigm based on the notion of something evolving from nothing. The second section will explore the clinical process of gout suffers from the perspective of a medical model in understanding the chemical imbalances that create the pathway of a gout attack, the compounds that are found within this process that signpost this pathway and to connect uric acid and crystallisation in gout. The clinical pathway on gout depicts a whakapapa order and the inter-relationships this pathway undertakes. The Final section investigates systems thinking within the two worlds: whakapapa paradigm, Māori human growth and development, clinical process for gout, demonstrating the intertwining of the two schools of thought.

Chapter six presents part one of the research analyses exploring the origins of Whakamā (inner consciousness, facial/body expressions) through Māori history and

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[4] Cram, F. (2012) Presentation to Ngati Hine Health Trust, Kawakawa, Bay of Islands

mythology. It explores Whakamā (inner consciousness, facial/body expressions) as an important construct in order to understand the interaction of Māori with each other and its various behavioural manifestations and possible causes. A whakapapa (genealogy) paradigm using Te Kore (abyss), Te Po (voids of light) and Te Ao marama (world of light) will be the framework to articulate and signal signposts of Whakamā patterns of behaviour and states of being. Finally this chapter discusses Whakamā and health drawing from the one to one and/or whānau/family interviews using Whakamā to unearth the myths about gout.

Chapter seven is the continuation of the research analysis in the development of a *whakapapa* model about gout through a wānanga approach. The *whakapapa* (genealogy) paradigm applied *Te Kore* (abyss), *Te Po* (voids of light) and *Te Ao Marama* (world of light) to articulate and signal signposts of gout behaviours, characteristics and states of being. Buck, T.H. (1949) growth model *Te Pu* (root cause), *Te Weu* (rootlets), *Te More* (taproot), *Te Aka* (vine) and *Te Tipuranga* (growth), provides the growth and development within the whakapapa paradigm that connects behaviour and lifestyles requiring consideration for recovery. The clinical framework applied explored the process about gout and its pathway through the body. Finally these frameworks are presented as a dual paradigm in supporting Māori gout suffers and their whānau enable them to seek support through their General Practitioner or health professional.

Chapter eight reviews and reflects upon the positioning of this research. The evidence of health disparities between Māori and non-Māori were presented and evidenced in New Zealand’s colonial history, (Ministry of Health, 2010:1). Such differences suggest complex components that are associated with socio-economic and lifestyle factors, availability of health care and discrimination. Improving access to health services in New Zealand is critical to addressing health disparities and according to (Robson B., Harris R., (Eds) (2007) their evidence suggests that Māori are less likely to access health services than non-Māori. A number of other barriers have been identified for Māori not seeking healthcare services, and the majority of these were related to the health system not dealing appropriately with cultural issues. Furthermore, Māori men score worst of all New Zealand groups on a number of health indices, and have some of the poorest health records in the world in some areas aspects of health, disease and mortality, (Malcolm, L. 1996:109, 356-358). Although there are many health related conditions for Māori that still require further investigation, this area of research focused on Gout. The result of this thesis was a *whakapapa* model about gout.

Chapter Two

Health Status of Māori in Aotearoa, New Zealand

This chapter examines social, economic, cultural and historical factors contributing to inequalities in health and the strategies proposed to reduce these inequalities will be investigated. Disparities in health status between different groups within a population are found worldwide. These disparities include socioeconomic position, ethnicity, age, gender, impairment, sexual orientation and geographical region. In Aotearoa, New Zealand, inequalities between Māori and non-Māori are the most consistent and compelling inequities in health (Ajwani, S., et al 2003: Ministry of Health and University of Otago 2006). Health inequalities or health inequities is widely used in this country. These are defined as differences which are unnecessary and avoidable but in addition are considered unfair and unjust (Whitehead, M. 1992:431). Whitehead suggests that:

> *"ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided…the aim is not to eliminate all health differences so that everyone has the same level of health, but rather to reduce or eliminate those which result from factors which are considered to be both avoidable and unfair."*

The absence of systematic disparities in health between social groups who have different levels of underlying social advantage/disadvantage, different position in a social hierarchy is further discussed by (Braveman, P., Gruskin, S. 2003:254) in that health equity monitors resources, evaluates the processes that determine how resources are shared and the underlying values of society.

Colonisation – A Tool of Social Injustice

It is impossible to understand Māori health status or interventions without an understanding of the colonial history of New Zealand. Through colonisation, new history, beliefs and values of indigenous peoples have being relabelled myths, legends and superstitions. The land is rediscovered and renamed according to the coloniser. If we do not recognise colonisation as a deliberate and continuous process it is easy to assume that colonising events are accidental, inevitable and over (Reid, P, Robson, B: 2006:4). To elaborate further, Churchill, W. (2006) discusses injustices of colonisation processes:

> *"Colonisation is based on dehumanising indigenous peoples. Dehumanisation occurs on a spectrum from genocide to neglect, from paternalism to romanticism. This dehumanisation depends on colonisers having a central belief in their own superiority and that they therefore have superior rights to the territory and resources of indigenous peoples."*

The ideology of white superiority of race derives from the presumption there is a hierarchy of peoples from black to white, where white is proposed to be more advanced genetically, biologically, intellectually, socially, culturally and spiritually. Although the hierarchy of different races has been discredited, the term race has popular usage today, known as race-based funding. In considering the usage of terminology suggests the foundations of white superiority are still alive and well in our country today.

From the arrival of the missionaries, (Walker cited in Selby, 1999), missionaries were seen as the party to cultural invasion and had two pronged goals; one was to convert Māori to Christianity and the other was to transform Māori from perceived barbarism to civilised life. Frantz Fanon (1963: 63), who is not so accommodating of Christianity in the role of the Christian Churches, in that the colonisation process is damning:

> '*But the triumphant communiqués from the missions are in fact a source of information concerning the implantation of foreign influences in the core of the colonised people. I speak of the Christian religion, and no one need be astonished. The Church in the colonies is the white peoples' Church, the foreigners Church. She does not call the native to God's ways, but to the ways of the white man, of the master, of the oppressor. And as we know, in this matter many are called but few are chosen.'*

Fanon, F. (1963) challenged the Church in the colonies is a powerful tool in terms of the psychological indoctrination. The missionaries were the vanguard of colonisation. Colonisation was a process that involved the alienation of the native peoples from their natural resources (land), creating social and cultural disruption, and invariably impoverishment. The psychological ramifications of colonisation remained uncharted territory until Fanon, F. (1967) who was also a French trained psychiatrist, linked psychiatric disorders amongst Algerians with the war of independence:

> *'The period of colonisation when it is not contested by armed resistance, when the sum total of harmful nervous stimuli overstep a certain threshold, the defensive attitudes of the natives give way and they find themselves crowding mental hospitals. There is thus during this calm period of successful colonisation a regular and important mental pathology which is the direct product of oppression.'*

McNeill, H. (2005) contends that this explains the phenomenon of colonised peoples in different parts of the world sharing common psychological disorders. The mental health problems of Māori, manifest in destructive social behaviours can be observed in other colonised peoples who also identify the colonial experience as the root cause. The Sioux Nations, Seven Fires Council accuses the American institutions of encouraging the hegemonic practices amongst their people as an effective colonising strategy:

> *'Indigenous groups in many parts of the world have been reported as having increased rates of suicide. This is so in the Inuit in Canada, in the American Indians, in the New Zealand Māori, and in Australian Aborigines. The reason for the increased rate of suicide is complex and involves socio-cultural factors in addition to associated mental disorders. Indeed, in such groups the socio-cultural factors probably predominate, as those groups have often suffered quite extreme social, environmental and emotional deprivation, with disruption of their traditional values. Often this leads to alcohol and substance abuse. The main aim in influencing the overall suicide rate of such communities involves political action rather than specific individual treatment, but it should not be forgotten that the prevention of individual suicide is essentially a personal matter and emotional suffering must be addressed along the usual lines*[5]

Colonisation permits the misappropriation and transfer of power and resources from the indigenous peoples to the colonisers. This process of transfer was through assimilation indoctrination, layers of new systems over the centuries have established and determined how resources are obtained, distributed and to whom. As new systems are introduced, so too are changes in values and promoting new ideas that are determined by the dominant culture. This process is described further by Reid, P., Robson, R. (2006:5) stating:

> *'Māori move from being normal to being different from Pākeha, Non-Māori, non-indigenous norms…Māori rights as tangata whenua are appropriated as we become marginalised, reclassified and scrutinised as outsiders.'*

Socio-economic status greatly impacts on indigenous peoples' health as stated by Gracey, M. (2007: 16) in her writing about the poor health of Indigenous people in Australia. In some instances this is reflected in Aotearoa, New Zealand in the Māori community too. Poor health can be seen as another barrier to care when:

> *"social factors like poverty, inferior housing, severe overcrowding, poor standards of domestic and community hygiene, racial discrimination, educational disadvantages,*

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[5] Cited in McNeil, H. (2005). Te Hau Ora o Nga Kaumatua o tuhoe – Tuhoe Kaumatua Mental health. A Thesis submitted for the Degree of Doctoral of Philosophy, Auckland Institute of Technology.

> *high unemployment rates and heavy dependence on social welfare along with limited access to affordable and nutritious food and poor understanding of health and nutrition all increase the risk of chronic disease in indigenous people."*

Furthermore, in a commentary written by Welch, D. (2006:21) in the Listener on a similar topic indicated the following:

> *"Māori are dying younger than Pākeha….because they are poorer, colder, sicker and more socially disadvantaged, are less likely to get help and not least because they live in a predominantly Pākeha world". This all stems back to those three words 'racism, discrimination and colonisation.'*

The Impact of Colonisation On Māori

When Europeans came to these lands, Aotearoa, New Zealand, things changed, and today we see that indigenous/ethnic people have become reliant on fast foods, and high-risk behaviours like poor nutrition, alcohol abuse, cigarette smoking and a sedentary lifestyle., the result is poorer health status and outcomes for Māori living in New Zealand, (Gracey 2007).

Durie, M. (2003) states Māori were pushed by the European to live in low lying villages, they left behind their main sources of food; fern roots, kumara, fish, birds and berries, and were replaced by foods like flour, sugar, tea, salted pork, potatoes, along with smoking, alcohol and drug misuse, less exercise, over-eating, and long-term unemployment. While infectious diseases declined and the decline in population had slowed, urbanisation brought about other health risks with this change in life-style and genetic influences.

The first recorded contact between Māori and Europeans occurred in 1769, at the time of James Cook's expedition to New Zealand from Britain, (Pool, I. 1991). In 1840 the Treaty of Waitangi, a formal agreement for British settlement that guaranteed protection of Māori interests, was signed by representatives of the British crown and some of the Māori chiefs. It is estimated that Māori numbered approximately 80,000 at that time, along with a population of about 2,000 settlers. The signing of the Treaty facilitated a large-scale influx of British migrants, indicated a decline in the Māori population and an increase in the number of settlers, both groups numbering approximately 59,000 by 1858. By 1901, the country's demographics had drastically altered, with the population of 770,313 settlers outnumbering the Māori.

The introduction of firearms and new infectious diseases brought in by settlers had a major impact on the health of Māori resulting in an increase rate of deaths. However, the historical and socioeconomic context in relation to Māori mortality after the colonisation of New Zealand, specifically Māori loss of land, was also important, (Kunitz, S.J. (1994). Sorrenson, M.P.K. (1956), Kunitz, S. (1994) further noted.

> *"Death from disease did not occur to the same extent among those indigenous peoples who kept their land (such as in Samoa and Tonga) as among those who did not, because disruption of their economic base, food supplies, and social networks was far less widespread."*

The destruction of the colonial power is further emphasised by Durie, M. (1998) who states:

> *"For Māori, this disruption not only occurred via land confiscation made possible through acts of law but also extended to legislation in many other areas, including regulation of Māori rights and discrimination against the use of Māori language in schools, all of which have affected the health of Māori people."*

The treaty's intention was to protect and maintain the well-being of all citizens, and its health implications relating to processes of good government and notions of participation and equity are important. Ratima, M. (2001) states the primary mechanism of the Treaty of Waitangi, for Māori, provided their unique rights as the indigenous people of New Zealand for breaches to be addressed. Since the 1970s, public awareness of the Treaty of Waitangi has continued to increase, primarily as a result of growing Māori aspirations for self-determination. In particular, it has been argued that the continuing disparities in health between Māori and non-Māori represent evidence that Māori health rights are not being protected as guaranteed under the treaty and that social, cultural, economic, and political factors cannot be overlooked in terms of their contribution to the health status of this group, (Pomare, E.W. et al. 2000).[6]

In several Government health documents; NZ Health Strategy (2000), Primary Health Strategy (2001) and He Korowai Oranga (2002) noted that the indigenous status of Māori has been recognized, and the Treaty of Waitangi has been acknowledged as a fundamental component of the relationship between Māori and the government. Although the status and recognition of the Treaty is acknowledged, it is important to note that the treaty has never been included in social policy legislation, it is clear there is a gap between acceptance of the treaty and translation of its aims into actual health gains for Māori, (Durie, M. 1994).

Health Status between Māori and Non-Māori Populations

Although the decline of Māori in 1896 of approximately 42000 seemed dim, Māori population began to increase in subsequent years. Government-initiated public health services and Māori-controlled health promotion programs, including the appointment of Māori health inspectors to work within Māori communities, contributed to this gradual recovery, (Pool, I.,

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[6] Timeline of The Treaty. The Treaty of Waitangi Information Programme. State Services Commission, Wellington, New Zealand.

1991., Durie, M. 1994., Dow, D.A. 1999). It also saw a decline in mortality rates which may have been the result of the introduction of a national health care scheme and social welfare system in 1938 and improvements in treatment methods. Up until the 1930's Māori lived primarily in rural communities, with the loss of land, many Māori left their Papakainga (homeland) to seek employment in the 'big smoke,' this led to a large-scale urban migration. This situation paralleled changes in New Zealand's economy, which shifted from an agricultural focus to the production of manufactured goods, (Pool, I. 1991). The following population data is based on the rate per 100,000.

Māori fertility rates remained elevated both through the period of severe mortality decline and as mortality rates improved, resulting in a population with an age structure that is relatively young. In 2001, 37% of Māori were younger than 15 years, compared with 23% of New Zealand's overall population, and 3% were 65 years or older, as opposed to 12% of the country's overall population. In the release of Tatau Kahukura (2010) the population projection, based on the 2006 Census, indicates that the Māori population has a high growth rate of 1.4% as to non-Māori annual increase of 0.7%. It is projected with these increases between 2011 and 2026 the Māori population is predicted to grow by 21% whereas non-Māori population is predicted to grow by only 11%. These increases in population rates are due to a number of drivers, one of which is a higher fertility rate for Māori females compared with non-Māori females. For example in 2008, the total fertility rate for Māori was 2.95% compared with 2.01% for non-Māori. These figures represent the fertility rate are the average of live births. The other factor is Māori have a younger age structure and an age group for fertility (15-44 years).

Life expectancy has increased among the indigenous populations of New Zealand, Australia, Canada, and the United States over time but has never matched that of the non-indigenous populations of these countries, (Kunitz, S. 1994). There has been a consistent increase in life expectancy among Māori since the 1950s, but recent data indicate a widening gap between Māori and non-Māori, (Ajwani, S., Blakely, T., Robson. B., Tobias, M., Bonne M: 2003). For example, male non-Māori life expectancy at birth was 70.9 years during the period 1980 to 1984, increasing to 75.7 years during 1996 to 1999; life expectancy among women increased from 77.2 years to 80.8 years. In contrast, Māori life expectancy at birth increased from only 64.6 years to 65.8 years among men and from 69.4 years to 71.0 years among women. Thus, during this period, the gap in life expectancy between Māori and non-Māori increased among both men (from 6.3 to 9.9 years) and women (from 7.8 to 9.8 years). Māori life expectancy rapidly increased up until the late 1970s to early 1980s became stabilised while non-Māori continued to increase. Since the 1990's Māori life expectancy has been increasing at about the same rate as non-Māori (Blakely et al 2007).

Pomare, E.W. (1980) used data from 1954 through 1975 to provide a comprehensive overview of Māori health status. During the period examined, rates of cause-specific mortality, including deaths from respiratory diseases, infectious diseases, cardiovascular diseases, diabetes, cancer, and unintentional injuries, were higher among Māori than non-Māori. Mortality rates have since declined for some diseases, but disparities between Māori and non-Māori remain, (Ajwani, S., Blakely, T., Robson, B., Tobias, M., Bonne, M: 2003). For example, during 1996 to 1999, age-standardized cardiovascular disease mortality rates were 264.9 and 78.5 per 100,000 among Māori and non-Māori, respectively, and the corresponding respiratory disease mortality rates were 54.5 and 16.7 per 100,000. Also, there is recent evidence of increasing cancer mortality rates among Māori; age-standardized rates (per 100,000) were 189.7 in 1980 to 1984 and 215.2 in 1996 to 1999, as compared with rates of 119.4 and 104.4, respectively, among non-Māori. In 2001 Census, cardiovascular disease mortality was two and a half times higher for Māori than non-Māori, and Māori were twice as likely to be hospitalised for cardiovascular disease as non-Māori. Stroke mortality was over one and a half times higher for Māori than for non-Māori, and Māori rates for hospitalisation were twice that of non-Māori. The heart failure mortality for Māori was almost twice as high as non-Māori. Māori were four and half times likely to be hospitalised for heart failure than non-Māori. Rheumatic heart disease was over six times higher in Māori than non-Māori and four times higher hospitalisation rates for Māori than non-Māori.

The Ministry of Health (2001) Census indicated the major cause of death for Māori and non-Māori was ischemic heart disease, with lung cancer being the second cause of death for Māori and was also the top five causes of death for non-Māori. The top five deaths featured for Māori male and female was diabetes, but not a top five for non-Māori male and females. The fourth leading cause of death for Māori males was suicide which was the second leading cause of death for non-Māori. Apart from suicide for males, the major cause of death was all chronic diseases. Breast cancer was the third leading cause of death for both Māori and non-Māori females.

There were significantly higher cancer registrations for all cancers for Māori adults than non-Māori adults. Māori mortality rates were almost twice those of non-Māori. The most common cancer for Māori females were breast (1.3 times higher than non-Māori females), lung (four times higher than non-Māori females), colorectal, uterine and stomach. The most common cause of cancer death for Māori male is lung (three times higher than non-Māori male), prostate (significantly lower than non-Māori, however Māori mortality rate was almost twice that of non-Māori), colorectal, stomach (three times higher than non-Māori, with mortality rates also three times higher than non-Māori) and liver (three and a half times that of non-Māori males). What this suggests is that Māori with cancer have a higher risk of dying from their cancer than non-Māori (Harris, R. et al. 2007).

Similarly, although overall hospital discharge rates among both Māori and non-Māori increased in all age groups between 1970 and 1992, Māori rates continue to be 1.4 to 2.5 times higher than non-Māori rates, (Pomare, E., Keefe-Ormsby, V., Ormsby, C. 1995. Ministry of Health. 1999). In 1997, Māori hospitalization rates were 40% higher for both infectious diseases and respiratory disorders and more than 100% higher for endocrine disorders than non-Māori. In the 2001 Census, avoidable mortality rates were over two and a half times higher for Māori than non-Māori. Amenable mortality rates were more than two times higher for Māori than non-Māori.

For Māori avoidable and ambulatory-sensitive hospitalisation rates were over one and a half times higher than non-Māori. In the New Zealand Health Survey (2006/07), Māori aged 5-34 years were twice more likely to be hospitalised for asthma than non-Māori. The prevalence rate of asthma reported by Māori aged 15-45 years, were almost one and a half times greater than non-Māori. Māori aged 45 years and over hospitalised for a chronic obstructive pulmonary disease (COPD) rate were over four times than they were for non-Māori. The relative disparity was greatest for Māori females whose COPD rate for hospitalisation was five times more than for non-Māori females. The COPD mortality rate was three times higher for Māori aged 45 years and over than non-Māori, with disparities, as noted previously, greater for females.

The Ministry of Health (2010) indicated that suicide and intentional self-harm rates for hospitalisation among Māori were higher than non-Māori and in particular the disparity is greatest in males, with Māori males almost one and a half times more likely to be hospitalised for intentional self-harm than non-Māori males. However, overall women are more likely to be hospitalised for intentional self-harm than men. For Māori suicide mortality rates were twice more than non-Māori and males had a higher mortality rate than female. The highest mortality rates were identified between aged 15-44 years for both Māori and non-Māori. The common forms of intentional self-harm for male were more aggressive options such as hanging and weapons, whereas females were more likely to attempt suicide from an overdose.

A report released by Fortune, S., et al. (2010) on the health and wellbeing of secondary school students during 2001 and 2007 Youth2000 survey, captured a random sample of more than 9,000 students attending mainstream secondary schools, but not necessarily all young people in New Zealand. This report concluded, in 2007 the students' reports indicated that within the previous 12 months, 26.0% of female students and 6.1% of male students had deliberately hurt themselves or done something they knew may have harmed or even killed them. A further 19.4% of female students and nine point four percent (9.4%) of male students had suicidal thoughts, 11.5% of female students and 6.1% of male students made suicide plans, 6.7% of female students and 2.9% of male students had attempted suicide. Of the students who reported a suicide attempt, 21.5% did not report having serious suicidal thoughts. In terms of gender disparities, Suicide behaviours, self-harm, depression and mental health difficulties were all higher in females than males. Māori students were more likely than NZ European students to report suicidal thoughts (17.4% vs.12.4%), suicide plans (11.1% vs. 7.4%) and suicide attempts (6.9% vs. 3.6%). Pacific students were more likely than NZ European students to report a suicide plan (10.8% vs. 7.4%) and suicide attempts (8.2% vs. 3.6%). Depressive symptoms were more common in Asian students (13.5%) than NZ European students (9.3%).

The rates for interpersonal violence for Māori adults were more likely than non-Māori adults to suffer adverse health effects as victims of violence. The mortality rates from assaults and homicide were more than four times higher for Māori than non-Māori. In terms of hospitalisation rates as a result of assault or attempted homicide were also higher for Māori than non-Māori. The disparities were greatly higher among Māori females for hospitalisation as a result of assaults and attempted homicide than non-Māori females. In fact Māori females were over six and a half times higher for hospitalisation rates than non-Māori females.

In 2009 a report commissioned by the Ministry of Justice to provide information about violence and young people in New Zealand secondary schools completed a survey where 9,000 students participated. They were mainstream schools were students attended but does not represent all the New Zealand youth population. This report noted the trends towards greater violence among young people are perplexing. Youth violence is a major issue not only in the youth justice system but the whole community. School bullying, 72% was done through the use of mobile phones, 41% students reported they had been hit or physically harmed by another student in the last 12 months; 35% reported they had hit or physically harmed another person one or more times in the last 12 months; almost 20% reported they had been in a serious physical fight in the previous 12 months, with 6% reporting they carried weapons. There were 20% of female students report having been touched in a sexual way or made to do things that they do not want to do. It was also noted most of the key causative factors for youth female offending was as a result of sexual abuse. There were 10% of students were worried someone would hurt or bother them at school and it was clear school bullying was a very traumatic experience. In terms of witnessing family violence in the home there were 17% of students and over 12% of young people report being kicked, hit or punched in their home, (Clark, T.C., Robinson, E., Crengle, S., Grant, S., Galbreath, R.A. & Sykora, J, 2009).

For both Māori and non-Māori populations, self reported prevalence for diabetes (aged 15+), but the disparities are very high between Māori and non Māori when relating to complications. Renal failure rates for diabetes (aged 15+) were over eight and a half times in Māori than non-Māori.

In a study conducted by Gow, P., Winnard, D. (2010) who estimated the prevalence of gout for the entire population living in Aotearoa New Zealand, using national level administrative databases of health care and medication use. The results demonstrated a high overall national prevalence of gout, 2.69% and a prevalence of 3.75% in people aged ≥20 years. It also confirmed that gout is more common among Māori and Pacific people, males, people with advancing age, and people living in socioeconomically deprived areas. The analysis raises a number of issues about methods of assessment of gout prevalence in large population-based studies and gout epidemiology, and has implications for clinical and public health practice. The result for Māori of 6.06% is similar to those reported in the Australian Aboriginal community study. Ethnicity and socioeconomic results highlight gout as an important burden of disease for populations who already have significant health disparities.

Infectious disease rates, meningococcal notifications were twice as high for Māori than non-Māori and in particular, the notification rates for Māori infants/toddlers aged 0-4 years were over three times higher than non-Māori. The ages 5-19 years were similar for both Māori and non-Māori. Tuberculosis notifications were over one and a half times higher for Māori than non-Māori males and no significant difference between Māori and non-Māori females. Rheumatic fever rates for Māori were over five and a half times higher than non-Māori and hospitalisations and mortality rates for rheumatic heart disease were also higher for Māori than non-Māori. Child immunisation rates from the National Immunisation Survey 2005 indicated at the age of 2 years 73.2% of Māori children had completed their immunisations for their age group compared to 82.5 for non-Māori children.

In the 2006 New Zealand Household Disability Survey it was estimated that 95,700 Māori living in New Zealand 17 percent of this population were living with a disability. The Disability and Māori in New Zealand (2006) report indicated the age standardised disability rate for Māori was 19% compared with a rate of 13% for non-Māori (Office for Disability Issues and Statistics New Zealand 2010). There were 14% of Māori children aged 0-14 years (28,200) had a disability compared to 9% of non-Māori children. The most common disability type experienced by Māori children was special education needs and chronic conditions (both 5 percent). In terms of Māori adults (aged 15 years and over) 14 percent had a disability compared with 17 percent of non-Māori adults.

Health Disparities between Māori and Non-Māori

A number of different explanations have been suggested for the inequalities in health between Māori and non-Māori. One common suggestion is that these differences are due to genetic factors, (Hall, A., Stewart, R. 1989). However, about 85% of genetic variation occurs randomly and is not related to race or ethnicity. The striking time trends in Māori mortality and morbidity during the 20th century demonstrate that environmental factors played a major role, (Pearce N., Foliaki, S., Cunningham, C., Sporle A. 2004). Thus, although genetic factors may contribute to differences in health status between Māori and non-Māori in the case of certain specific conditions, they do not play a major role in population and public health terms.

In the writings of Pearce, N.E. (2005) explained the non-genetic explanations for differences in health between Māori and non-Māori can be grouped into four significant areas focusing on socioeconomic factors, lifestyle factors, access to health care, and discrimination. These explanations are not mutually exclusive, but it is useful to consider them separately while bearing in mind that they are inextricably linked.

The Impact Socio-economic Factors on Māori Health

Socioeconomic position is regarded as important determinants of health factors such as; income, employment status, housing, education that have both direct and indirect impacts on health and have cumulative effects over lifetimes, (Harris, R., et al. 2007). The first studies to assess the role of socioeconomic factors and health status differences between Māori and non-Māori investigated mortality in men aged 15 to 64 years, (Pearce, N.E., Davis, P.B., Smith, A.H., Foster, F.H. 1985; Pearce, N.E., Pomare, E., Marshall, S., Borman, B. 1992. Sporle, A., Pearce, N., Davis, P. 2002). During this period these analyses showed that Māori men were more than twice as likely as non-Māori men to die prematurely; also, mortality rates among Māori men were significantly higher in each socioeconomic class grouping, and mortality differences among these men were greater within their own ethnic social class groups as well, (Sporle, A., Davis, P. 2002).

The 2006 Census socioeconomic indicators show that non-Māori were more advantaged than Māori across all socioeconomic indicators presented. In school completion Māori male and female had a 43.5% rate compared to 63.7% in non-Māori male and female. Unemployment rates for Māori showed 7.6% were unemployed than non-Māori at 2.7%. Total personal income less than $10K 15+ years Māori rates were 25.5% and non-Māori (21.0%). Those receiving means-tested benefits (e.g. Domestic Purpose Benefit, Unemployment, Sickness, and Invalid) Māori rates were 26.7% and non-Māori 10.5%. Those living in a household without telephone access, Māori rates were 5.5% where as non-Māori were 1.2%. Those living in a household without motor vehicle access, Māori were 9.1% and non-Māori 5.0%. For those who were not living in their own home, Māori rates were 69.9% and non-Māori 43.7%. The final section in the socioeconomic determinants of health was household crowding Māori rates were 22.8% and non-Māori 7.9%.

Neighbourhood deprivation from the 2006 Census, use a small area based relative deprivation index on nine socioeconomic variables, categorised from 1 to 10 decile (higher the number the most deprived) and describes the deprivation experienced by groups of people in small areas and describes the general socioeconomic deprivation of an area. This report shows that higher proportions of Māori live in areas with the most deprived. The 2006 Census indicated 24% of Māori lived in decile 10 areas compared to non-Māori 7%, while only 3% of Māori lived in decile 1 areas compared to 12 percent of non-Māori.

A number of studies such as Eachnus, J. et al (1996) demonstrated increasing mortality and morbidity with increasing deprivation. The New Zealand Deprivation Index enables area-level assessments of socioeconomic deprivation through the use of census data. Area meshblocks (contain an average of 90 people) are ranked by means of a decile score of 1 to 10; the higher the score, the more deprived the neighbourhood, (Salmond, C., Crampton, P. 1984). Analyses using this index have shown that, for deciles 1 to 7, differences in life expectancy at birth between Māori and non-Māori are 5.8 years for men and 5.3 years for women; for the most deprived deciles (8–10), the differences are 8.2 years and 10.1 years, respectively. More than half of the Māori population (56%) live in areas ranked in deciles 8 to 10.

However, lower Māori health status is only partially explained by relative socioeconomic disadvantage; Māori mortality rates have been shown to be persistently high even after control for social class. Smith, A.H., Pearce, N.E. (2002) data analysis between 1974 to 1978, found that approximately twenty percent (20%) of the difference between Māori and non-Māori male mortality rates was attributable to differences in socioeconomic status, whereas 15% was linked to cigarette smoking; 10%, to alcohol consumption; 5%, to obesity; and 17%, to accidents. In addition, about 35% of excess Māori deaths were due to diseases for which effective health care was available.

Health literacy is defined as the ability to obtain and process and understand basic health information and services in order to make informed and appropriate health decisions, (MOH b, 2006). In this report on Adult literacy and life skills survey, for Māori and non-Māori males and females aged between 16-65; Māori males and females had significantly lower health literacy skills than non-Māori males and females. In the health literacy scores within 1 and 2 means that an individual has insufficient skills to cope with the health literacy demands they face. Level 3 describes the minimum required for individuals to meet the complex demands of everyday life and work in the emerging knowledge based community. The distribution of health literacy rates within level 1 and 2 for Māori male were 80% compared to rates for non-Māori were 53%. Māori female rates were 74% and non-Māori females were 55%. Those who scored over level 3, Māori males rates were 19% and non-Māori 45%. Māori females were 26% and non-Māori 45%.

The Impact of Lifestyle Factors on Māori Health

In this section it can be argued that smoking, alcohol and drug use and obesity, relate to individual risk and protective factors and are linked to socioeconomic determinants. In 1999, the national surveys showed that Māori smoke tobacco at a higher rate than non-Māori (53% vs. 20%). In the New 'Zealand Tobacco Survey 2008, it was reported that the prevalence of tobacco smoking among young people aged 14-15 years, Māori was higher than that among non-Māori (17.3 percent and 4.4 percent respectively). Adults aged 15-64 years; Māori were twice as likely as non-Māori adults to smoke tobacco. Māori females had the highest prevalence of tobacco smoking, while 50% reported being a current smoker.

The New Zealand Alcohol and Drug Use Survey 2007/08, Māori and non- Māori adults were equally likely to have consumed alcohol in the past year. Māori were less likely than non-Māori adults to have drunk alcohol daily in the past year. However, in those who had drunk in the past year, Māori were more than likely than non-Māori to have consumed a large amount of alcohol weekly. Ameratunga, S., et al. (2011) conducted a survey on youth and alcohol survey among 9,000 students, noted that students who lived in more deprived neighbourhoods were less likely to be current drinkers (deprivation 56.2%, medium deprivation 61.3%, and low deprivation 62.6%. Asian and Pacific students were less likely than Māori and NZ European students to have ever drunk, or to currently drink. When asked to indicate the reasons they drink alcohol, most current drinkers in 2007 reported their reasons for drinking was: 'to have fun' (77.4%), 'to enjoy parties' (56.1%), 'to get drunk' (41.0%) or 'to relax' (36.6%), with smaller proportions reported reasons such as 'to make me feel more confident' (22.3%), 'to forget about things' (21.6%), 'because I'm bored' (21.1%) and 'because my friends do' (21.0%).

Healthy body size is recognised as important for good health and wellbeing, with evidence showing that obese children and adults are at greater risk of short and long term health consequences (Ministry of Health, 2008). The New Zealand Health Survey 2007/08 used Body Mass Index (BMI) that indicates excess body weight according to weight and height and is calculated by dividing weight in kilograms by the square of height in metres (kg/m2). Children aged 5-14 years, Māori and non-Māori had similar prevalence of being overweight, but Māori girls were nearly 1.4 times more likely to be overweight than non-Māori girls. The prevalence of obesity in Māori children was more than one and a half times greater than that in non-Māori children. Māori adults were slightly less likely than non-Māori to be overweight. However, for Māori adults, they were more than one and a half times more likely to be obese than non-Māori.

Utilisation of Health Services among Māori Communities

In the 1930s New Zealand's national health care system was established to provide free medical care by salaried medical practitioners. During this period changes in the system from a free medical care service to a government-paid fee-for-service subsidy with secondary care under state control and funding, this remained unchanged until the 1980s. From this point the system had a radical public sector restructuring resulting in extensive changes to the social services system based on a competitive market model, (Scott, C. 1996). In 1991, a series of major health service reforms were initiated, in particular, two important changes that concerned the way in which public hospital and population health services were organized and delivered and a new funding scheme for the provision of primary health care enabling health practitioners to work together to provide contracted primary care services, (Borren, P., Maynard, A. 1994). It was within this context that a pair of Māori-led initiatives concerned primarily with improving access to services among Māori was undertaken: the establishment of Māori health care provider services and the development of cultural safety education.

As noted earlier, a significant proportion of the excess mortality among Māori stems from diseases for which effective health care is available, suggesting differences in access to health care, (Pomare, E. et al. 1995. Sporle, A. 2002. Smith, A.H., Pearce, N.E. 1984). In this context, access has been described in terms of both "access to" and "access through" health care, with focus on primary health care providers. Primary health care providers are a person's first point of contact with the health system and generally accessed through their local General Practice (GP) clinic. Health care need and health care quality have been developed into a framework for measuring disparities in access to care in the United States, a framework that includes broader environmental and societal factors (e.g., racism) that may affect access.

There are several reports that have been written during 1990's through to early 2000's indicating increasing evidence that Māori and non-Māori differ in terms of access to both primary and secondary health care services, (Baxter, J. 2002. Westbrook, I., Baxter, J. Hogan, J. 2001), that Māori are less likely to be referred for surgical care and specialist services, and that, given the disparities in mortality, they receive lower than expected levels of quality hospital care than non-Māori. (Malcolm, L. 1996., Davis, P., Lay-Yee, R., Sinclair, O., Gribben, B. 1997).One survey showed that thirty-eight percent (38%) of Māori adults reported problems in obtaining necessary care in their local area, as compared with sixteen percent (16%) of non-Māori. Māori were almost twice as likely as non-Māori (34% vs 18%) to have gone without health care in the past year because of the cost of such care, (Shoen, C., Doty, M.M. 2004). This adds to previous evidence that cost is a significant barrier to Māori access to health services, (Ministry of Health. 1999., Baxter, J., et al (2002), Pomare, E.W., et al. 1991.

The 2006/07 New Zealand Health Survey identified that the usual health practitioner for Māori and non-Māori adults were through their GP, Māori adults were equally as likely as non-Māori adults to report having a usual health practitioner. Māori males were slightly less likely to have seen a GP in the last 12 months than non-Māori males. Māori females were nearly two and a half times more likely to report an unmet need for a GP in the last 12 months than non-Māori females. The cost of GP visits was the main reason given by Māori males and females for not visiting a GP when they needed to. The other issue reported was lack of transport was significantly more likely to be a barrier to accessing GP care for Māori females than for non-Māori females. For visits to a Māori health provider 7% of Māori adults reported usually going to a Māori health provider first when unwell or injured. Māori females were more likely than Māori males to have seen a Māori health provider. Māori who have a Māori health care provider 83% had seen their provider with the last 12 months. The most common reason for Māori visiting the Māori health provider in the last 12 months was because it was cheaper. The next common reasons included: the provider was the closest, a friend or relative had referred them and feeling more comfortable talking to someone who understands their culture.

Other barriers existing for Māori accessing health services, Pomare, E.W. et al. (1991) states in his publication on a review on Māori asthma reported that "*conscious or unconscious attitudes of health workers contribute to reluctance by Māori to seek medical care for their asthma until it is absolutely necessary.*" Simons, L.A., Simons, J. (1998) wrote an article for the diabetic medical journal reported:

> *"Barriers to accessing diabetes care among Māori, including unsatisfactory previous encounters with professionals and experiences of disempowerment."*

Doctors have been shown to be less likely to advocate for preventive measures for Māori patients than for non-Māori patients and Māori may be less likely than non-Māori to be referred for surgical care, (Westbrook, I. et al. 2001). In 2008 a study undertaken by Māuri Ora Associates provided coverage on Māori across the country and their experiences of health services. It examined Māori perceptions of the healthcare system and what Māori themselves identified as barriers to access. The research report sought to understand the expectations, preferences and experiences of Māori consumers of health and disability services, including Accident Compensation Corporation (ACC) services and increase understanding of services provided to Māori. A further objective of the research was to test the validity of the survey tool with Māori consumers and individual questions and how well services meet the needs and expectations of Māori.

The survey findings showed, Māori were reasonably satisfied with their encounters within the health services including ACC. It was also noted a sub-group of those questioned expressed disapproval for the health care they and the general Māori community received. A significant finding though participants talked less about socio-economic barriers to health care and more about whether they were treated with respect, whether the service was value for money and the clinical skills of health workers. The report indicated the judgements about respect, value and skill may signal Māori consumers growing willingness to voice their concerns about their experiences of disrespect, racism and clinical practice. According to Jensen, P. et al. (2008: 12) are:

> *"The challenge for the health system is to 'up its game' by improving its delivery of health care services that are appropriate, accessible and effective for Māori. It this way, the health system can become a leading solution in the crisis in Māori health that is evident in current disparities.*

Māori-led Initiatives

Māori leadership has played a key role in advancing health promotion and disease control activities within Māori communities since the beginning of the 20th century. (Durie, M.1994, Dow, D.A. 1999). During this period Māori-led initiatives have played an important part for national and local approaches that were committed to advancing Māori health. These initiatives occurred outside of the mainstream services being provided at the time, which made them vulnerable to changes in government and funding availability. An opportunity for the focused development of Māori provider services emerged with the introduction of the 1991 health reforms. However, this restructuring of health and social services also led to a widening gap in inequality, as evident in such key determinants of health as income, education, employment, and housing. Moreover, the reforms had direct effects on the health of Māori, particularly that of children, (Blaiklock, A.J., Ciro, C.A., Belgrave, M., Low, W., Davenport, E., Hassall, I.B. 2002).

Māori health services use of Māori models of health and promotion of positive Māori development are two key philosophies underpinning Māori primary and secondary health care services. Māori cultural processes used as a basis for developing and delivering contemporary health services that support self-sufficiency and Māori control are crucial to the success of these provider organizations. Māori provider services have specifically identified access issues as a key factor and have used a range of strategies to address these issues, including extensive mobile services and outreach clinics, free or low-cost health care, employment of primarily Māori staff who are more likely to have access to Māori consumers in their communities, (Crengle, S. 2000) and active inclusion of the community in the planning and delivery of services.

The number of Māori health providers increased from 13 in 1993 to 240 in 2004 but continue to face a number of difficulties. Kiro, C.A. (2000) explains some of the difficulties experienced by Māori health providers are:

> *"A lack of good primary health data, such as ethnicity data, has limited the potential of many Māori health providers, and a small Māori health work-force has been quickly absorbed into the growing number of Māori provider organizations. Also, the short contract time frames in place require extensive renegotiations each year. In addition, because Māori providers work primarily with families at high levels of need in terms of health services, increased costs are inevitable if health gains are to be achieved, and funders must take this situation into account."*

Similar policy initiatives have recently been adopted in Canada and Australia to improve the health of indigenous peoples; however, the contractual environments in these countries lean toward single multiyear funding contracts for comprehensive primary health care, and there is early evidence that such systems are more efficient for providers and promote better outcomes among consumers, (Lavoie, J. 2003). Although Māori health providers have played key initiatives for the health status of Māori, it is too early to assess how effective they have been. But these organisations should be viewed as representing one of a package of necessary long-term measures. Kiro, C.A. (2000), Pomare, et al (1995) further state:

> *"Although the evidence that such strategies are effective is not yet available, there is certainly evidence that the reverse is true; that is, health service provision with little Māori participation results in poor Māori outcomes."*

Government Initiatives

He Korowai Oranga (2002) is the Ministry of Health-Māori Health Strategy provides a framework for the public sector to take responsibility in supporting the health status of whānau. The over-all aim of this report is whānau ora-families supported to achieve their maximum health and wellbeing. The framework supports the building of whānau assets and strengths through public policy that promote and encourage whānau development. The strategy supports the crown and treaty partners to work together in good faith and supports tangata whenua led development and the building of a healthy nation

Improving Access for Māori through Mainstream Services

In parallel with the development of a system of Māori service providers, there have been initiatives to improve Māori access to “mainstream” services. One such initiative, cultural safety, is an educational framework designed to assess power relationships between health professionals and those they serve, (Ramsden, I. 2002). The initiative has been taught in New Zealand nursing and midwifery programs since 1992, and it is a requirement for nursing and midwifery registration examinations. In 1995, the International Council of Nurses adopted a resolution to develop guidelines for the implementation of cultural safety in nursing education and practice in all 118 of the council’s member countries. According to Papps. E. et al. (1996) cultural safety initiative refers to:

> *“Teaching of the history of New Zealand within its curricula and provides comprehensive information on the Treaty of Waitangi and the effects of colonization on the present-day health status of Māori.”*

It provides a template to identify conscious or unconscious cultural and social attitudes that affect student nurses or midwives in their provision of nursing care and to transform those attitudes. This in turn, enables students to see their effects through a framework of practice-related reflection and action. It is important that cultural safety be taught by nurses and midwives who can relate their teaching directly to practice situations. In cultural safety education, “culture” is defined in its broadest sense, and refers to any group or person who may differ from the nurse or midwife gender, sexual orientation, social or economic position, disability, age, religious beliefs, or ethnic group.

The cultural safety does not advocate a cultural immersion approach or the learning of customs of ethno-specific groups, in that this would promote a stereotypical view of culture over time, (Ramsden, I. 2000). Therefore, cultural safety does not imply teaching nurses and midwives to be experts in Māori culture, as history informs us that this could potentially led to disempowerment of Māori. To understand and confront issues of power and marginalisation, a critical component of cultural safety education is recognising the role of wider societal processes in maintaining health disparities between Māori and non-Māori through discrimination and racism, (Ramsden, I. 1994). In a dissertation paper by Ramsden, I. (2002) on cultural safety and nursing education made note to the issues of power and marginalisation as:

> *"This information was not seen to be relevant to nursing and midwifery practice, and the introduction of cultural safety education was controversial. In the initiative's early years, inaccurate media reports concerning the content and teaching of the curricula influenced the public's perceptions of and reactions to the program. This resulted in a political response in 1995, with the Nursing Council of New Zealand being required to review cultural safety education and report back to a parliamentary select committee."*

Cultural Responsiveness Framework

This framework has similar ideas to the notion of cultural safety, its purpose and function is similar and it is a framework that is commonly used within the nursing arena. Cultural responsiveness is being aware of and capable of functioning professionally in the context of cultural differences e.g. assessments. It builds capacity and skills to communicate effectively with your client/patients/colleagues and cultural difference. This assists the development of intervention strategies that recognise unique strengths and competencies of cultural difference. It assists the practitioner to identify and recognise factors of vulnerability.

Culturally responsive approaches integrate information, activities, and practice opportunities that interweave family centered practice approaches. These include services that respond effectively to the culturally influenced needs and issues of vulnerable families. It positions culturally relevant information that meets the needs of families and includes principles supporting personal and organisational strategies. These strategies should expand the knowledge base on culture, how to manage cultural diversity towards best practice. Cultural responsiveness requires professionals to be effective. Supports for cultural responsiveness must be evident in all stages of care programming–development, implementation, and monitoring, e.g. policy. The three main focal points of program design that can facilitate the development of culturally responsive services are organizational: structure, policies, and procedures, training, supervisory of staff roles and responsibilities.

It also refers to cultural competence; competence implies having the capacity to function effectively as an individual and an organisation within the context of the cultural beliefs, behaviors and needs prescribed by the consumer and community, (Hobgood et al 2006). It involves appropriate and effective communication which requires the willingness to listen to and learn from members of diverse cultures. The provision of service, information in languages at appropriate comprehension and literacy level and in the context of an individual's cultural beliefs and practices. An understanding of cultural competence implies the principles include awareness of the other, willingness, genuine interest, non judgmental, awareness of diversity, to overcome prejudice, skilled in cultural assessment of the patient, cultural assessment of oneself, an ability to care, taking health and illness behaviors into consideration, to have cultural knowledge, to be knowledgeable about other cultures. Having knowledge about world views, educational cultural knowledge, having knowledge about patient's worldviews, knowledge about the worldview of your profession, inter-professional relationships, using documented cultural knowledge, having cultural knowledge about encounters between people, reflective practice, culturally safe behaviors, shared team vision, clarification of values. Therefore cultural competence in practice requires more than acquisition of cultural knowledge, it requires an ongoing process of education and commitment.

It requires acknowledging cultural difference, a persons ethnicity, respecting cultural difference and basic human rights, strength and unity in diversity, acknowledge that there is inequity in our communities, be open to learning from other cultures and relate respectfully from your own culture, a commitment to developing cultural awareness/self reflection/attitudinal change, commitment to development knowledge, resist stereotyping and commitment to combat racism.

The extent to which the cultural safety, cultural education, cultural responsiveness is making a difference in terms of the quality of health care provided in New Zealand remains to be fully assessed and will ultimately be judged by those who are the recipients of health services.

Māori Health Inequalities Indicators

The Ministry of Health publications from 2002 to 2010 on inequalities illustrate Māori experience the greatest levels of health inequalities than non-Māori in New Zealand. Not only is the health status of Māori worse than that of non-Māori at all levels of deprivation, the gap between Māori and non-Māori increase. With the introduction of Māori health providers and better ways of accessing health related services, Māori appear to be taking more interest in participating in their own health and wellbeing, (Ministry of Health, 2009b).

Having the ability to navigate through the health system and accessing the best possible service for the whānau can be overwhelming for all concerned. Not only can it be overwhelming for whānau accessing but the health professionals who are working on behalf of them. The reports presented in this chapter, have raised issues not so much in socioeconomic factors, but more on their experiences of being treated fairly and being treated with respect. The other concern for Māori, they did not understand their illness to the point they were not confident to advocate on their behalf through the health system. This is evident in the high-representation of health status across the sector for Māori. It can also be argued a rationale for this high representation is the gap identified in the health literacy between Māori and non-Māori.

As noted, the distribution of health literacy rates (per 100,000) within level 1 and 2 for Māori male were 80% compared to rates for non-Māori was 53%). Māori female rates were 74% and non-Māori females were 55%. Those who scored over level 3, Māori males rates were 19% and non-Māori 45%. Māori females were 26% and non-Māori 45%. What this represents is 80% of Māori male and 74% Māori female rates (per 100,000) did not have the ability to obtain, process and understand basic health information in order for them to make an informed decision about their health, (Ministry of Health 2010).

This is a significant finding for this thesis that confirms not all Māori comprehend health literature, no matter how much the information has been offered in what health professionals deemed 'laymen' language. An important point in this research is gauging a paradigm shift of thinking about a medical model of treating symptoms to a *Te Ao Māori* (Māori worldview) thinking about gout. This paradigm shift is analysed by a pre-*Whakamā* questionnaire/post-*Whakamā* as a guiding principle to unearth myths about gout and a questionnaire/post-questionnaire about what participants 'know about gout' to what they now know about gout, as a result of the individual/whānau interviews and participation in the four *Wānanga* to develop a *whakapapa* (genealogical) framework. The intention of this research is to create an educational tool for Māori when engaging with health services about gout and as a teaching tool for medical communities when supporting Māori with gout. A limitation of this research is following up on the participants on completion of this research to see whether there is an improvement for Māori accessing health services.

Summary

Disparities in health between Māori and non-Māori have been evident for all of the colonial history of New Zealand. Although there have been significant improvements in the past 172 years, recent evidence indicates that the overall gap in life expectancy between these groups is widening rather than narrowing. (Pearce, N. et al. 2004). These differences are a complex mix of factors associated with socioeconomic and lifestyle characteristics, discrimination, and access to health care. Māori-led programs designed to improve health care access are taking a two-fold approach that supports both the development of Māori provider services and the enhancement of mainstream services through the provision of culturally safe care.

The new initiatives are a result through evidence indicating poorer health status of the indigenous people of New Zealand and their clear demand for improved health services. Māori provider organisations and cultural safety education are examples of initiatives that have emerged not in isolation but, rather, within a context of macro-level government policies that have been shown to either promote or greatly hinder the health status of indigenous peoples (Ramsden, I. 2002. Papps, E., Ramsden, I. 1996). This chapter examined the overall health status for Māori compared with non-Māori; the next chapter continues the health status of Māori through a literature review, specific to gout.

The prevalence of gout among Māori is the focus of chapter three. *Whakapapa* (genealogy) signifies a sequential order of events where history unfolds such as health. It is through whakapapa (genealogy) that ways of knowing when working with illnesses such as gout unfolds. The medical model continues this process of whakapapa (genealogy) through its history and examining the clinical process about gout. A picture of the health status of the Health indicators show that Māori have poorer health status and outcomes compared to non-Māori and are more likely to be exposed to risk factors for poor health.

Chapter Three

The Prevalence of Gout among Māori

Within *Te Ao Māori* (Māori worldview) reciting *whakapapa* (genealogy) as a sequential order of events, to lay one generation upon another; everything has *whakapapa* (genealogy) from the gods through to every living thing in this world that includes the mountains, rocks and land, (Barlow, C. 1991: 173). *Whakapapa* (genealogy) is critical to the wellbeing of the *whānau, hapu and Iwi*. It is through *whakapapa* (genealogy) history unfolds, history such as health. It is here that we find ways of working with the illness, the pathway undertaken and the pathway forward, (Patterson, J. 1992: 7). *Whakapapa* (genealogy) legitimates a Māori worldview which is at the heart of Māori knowledge, Māori ways of knowing, and Māori ways of acquiring new knowledge.

Te Ao Māori (Māori worldview): a perspective

In classical Māori society, all communication was oral and this included the handing down of tribal knowledge in the form of traditions, genealogy and mythology from generation to generation. Patterson, J. (1992) asserts the classical Māori society, consisted of Māori values and traditional narratives that portray the creation narrative. This begins with *Te Kore* (nothingness) the standing of time, and proceeds to describe the evolution of a series of Nights (*Te Po*), to *Rangi* (heaven) and *Papa* (earth). This notion is a metaphysical concept of important connections that depicts genealogical descent patterns.

The mythological traditions of the Māori dating from a very ancient period are held to be very sacred, that provides an account of the Cosmos of *Po* (night), *Te Ata (*morn), *Rangi* (heaven) and *Papa* (earth), recording the genealogical traditions preserved to the present time. The genealogies recorded hereafter are divisible into distinct epochs: the personified powers and nature of man, the religious worship of *karakia* (incantations, prayer) and the migration to New Zealand. Walker (1990) asserts that the mythological origin of Māori society consisted of three major myth cycles: *Ranginui* (sky-father) and *Papatuanuku* (earth mother), the demi-god *Maui* and the life of *Tawhaki*. It depicts the Māori phenomenology world of existence that contained in its vastness the seeds of the universe, the celestial realm, the domain of the gods, and the world of light that is the dwelling place of humans. *Whakapapa* becomes the most fundamental aspect of the way Māori think about and come to know the world (King, M. 1981). It is acknowledged as a way of thinking, a way of storing knowledge and a way of debating knowledge, (Smith, L. 1999).

Whakapapa (genealogy) is the means by which there is interpenetration of the realms of humans, into the realms of the dead and the realms of the gods. *Whakapapa* according to Barlow, C. (1991) is basis for organisation of knowledge in respect of the creation and the development of all things." In customary Māori society, 'myths' and 'legends' provide an understandable vehicle toward Māori worldviews. The legend of *Tane-nui-a-rangi* (one of the children of the sky-father and earth-mother) ascends to the highest heaven and obtaining from *Io*, the creator, and the three baskets of knowledge representing each of the three realms. According to Best, E. (1924: 125):

> *"Māori mythology bears the mark of a comparatively high plane of thought, and is the result of universal personification of natural phenomena, the higher phases of animism."*

Bishop, R., Glynn, T. (1999) describes the pre European system as pre-existing and complex and that colonisation sought to deny or belittle the existence of such a system. Māori had a sophisticated and functional system of development, prior to colonisation. Māori had a powerful knowledge base, a complex oral tradition and a dynamic ability to respond to new challenges and changing needs. These systems were important to the development of the *whānau* (extended family), *hapu* (sub-tribe) and *iwi* (tribe)in aspects relating to social, economic and political stability.

Jean-Jacques Rousseau was the first theorist in the eighteenth century to define education as a lifelong learning experience. This European notion of education was practiced in pre-European Māori society. According to Potaka, H. (1995) Māori knowledge and learning was transmitted throughout the *whānau, hapu* and *iwi* as a lifelong process. It emphasises the inter-relationship of teaching and learning were not separate concepts. Māori placed significant value on transmitted facts and beliefs, which reflected a high cultural value. Transmission involved a great deal of time and repetition and was fostered within the social context of underlying principles of the culture such as *mana* (prestige), *tapu (*sacred), *noa* (common, without tapu) and *mauri* (life force, energy). Furthermore, Marsden, M. (2003) asserts the world of Māori cosmogony providing interrelated topics of knowledge that provide sanctions, protocols and guidelines through Māori worldviews and value systems. It portrays an understanding of a holistic approach and the fundamental principles of Māori customs to everyday life integrated into the value systems of culture.

Bird, L., et al. (2000) provides more underlying principles in Māori development by explaining how traditional Māori values work together to inscribe a total ecology or cultural environment, where all aspects are interdependent upon all other aspects. These are deeply underpinned by values of *wairua* (spirituality*)*, *manaaki* (care for others) and *whānaungatanga* (maintaining the family) that are kept alive in rituals, stories and everyday contexts such as greetings. It was clear from the evidence that there was a sophisticated and functional system for Māori that consisted of a powerful knowledge base, complex oral traditions, rituals and Māori worldviews that reflected the interconnectedness of the various aspects of health and development underpinned by Māori social values.

According to Ratima, M. (2001), Māori customary knowledge and understanding founded on tribal values, beliefs and custom' presents a recognisable philosophical base. Today, it is cultivated in the discourse of Māori realities revealed by concepts such as *whakapapa* (genealogy), *whānaungatanga* (inter-relationships) and *mauri* (life source/energy). This framework for Māori development is supported by Loomis, T.M. (2000b) who argues that Māori have utilised customary conceptual frameworks and principles as the foundation for a holistic approach.

While there has not yet been a comprehensive articulation of Māori paradigms, there is some consensus among Māori development theorists that there are distinctly Māori worldviews, and that although they are implicit they underpin Māori development theory and practice, and have an integrated nature (Loomis, T.M. 2000b; Puketapu, 2000; Walker, 1990). Cultural advancement relies upon access to Māori resources. Increased access to Māori resources will require the protection, enhancement, and management of those resources as well as greater opportunities within New Zealand society for Māori cultural expression, (Durie, M., et al., 1995).

Contemporary Māori development has emerged from within, as a Māori-driven process to realise Māori self-determination and advancement. The decade of Māori development is a reference point for contemporary Māori development. Māori development is centred on people, rather than having a sole focus on economic growth. A distinctive feature of Māori development is that it is grounded on Māori worldviews and therefore draws on customary knowledge.

Māori models of health are holistic and locates individuals within the family context that recognise determinants of health (spiritual, cultural, social, and biological), emphasising continuity between the past and the present, and viewing good health as a balance between interacting variables. Ratima, M. (2001) contends Māori concepts of health place a greater emphasis on holism, and are distinct in incorporating a spiritual dimension and a focus on cultural integrity. These are features that are common with other indigenous peoples' understandings of health and, generally, Māori concepts of health are consistent with those of other indigenous peoples, (Loomis, T.M. (2000b).

Marsden, M. (2003:54-55) states that a number of key elements noting that myth and legends operate as part of the bodies of knowledge held within *whakapapa*, how one views the world, and ultimately reality within the relationship between the "Creator, the Universe, and Man.” Within the genealogical table of *whakapapa,* the world of symbols expressed by Marsden, M. is a place of knowledge that became a deliberate creation of the human mind which enables us to depict, represent, and illustrate some other perceived reality, words, formulae, forms, ritualistic ceremonies, legend and myth as maps, models, prototypes and paradigms which the mind can grasp, understand and reconcile the world of sense perception and the real world behind. This could also explain that knowledge held within *whakapapa* presents itself as a source of codes that requires engagement with the whole, and whereby the sacredness of knowledge means that the inner corpus of sacred knowledge was not to be shared with the common herd – least such knowledge be abused and misused.

The world of symbols described by Marsden, M. (2003: 57) was coded in such a way as to ensure that even when related in public; its inner meaning could not be understood without the key to unravel it. And unless all the parts were known and understood it was impossible to make sense of it. The establishment of this system of codes was the ideological tool to protect the retention of such knowledge so that the interconnectivity with the self, the other, and the woven universe sustained a balance of existence. The significance of the three baskets of knowledge is a conceptualisation that offers an invitation into understanding a Māori view around spiritual and cultural knowledge that identified through the genealogical table of whakapapa, a place of origin and validity for Māori. If within *whakapapa* is a layering of knowledge reflecting the reality and existence of a culture, then could using such wisdom for present day thinking be a significant and powerful source? Pere, R. (1984) refers to the power source as the means of protecting, retaining, expanding, and understanding knowledge of the Māori world and existence.

Research methods that have integrity with *Te Ao Māori* (Māori World View) models emphasis holistic approaches to health, education and social life includes Durie, M. (1984) Te Whare Tapa Wha model and has continued to be an inspiration to Māori research. While his latest model Te Pae Mahutonga is a cosmological orientation for health and whānau revitalisation. Charles Royal (1988), Linda Smith (1998) Fiona Cram et al (1997) argued for a critical and reflective approach for Māori researchers and raised consciousness to the colonising practices in research. Ranginui Walker (1992), Api Mahuika (1981) and Maharaia Winiata (1956) provide the impetus for kaupapa Māori theoretical frameworks in research. Māori customary knowledge and understanding founded on tribal values, beliefs and customs. *Whakapapa* not only authenticates Māori epistemology and its rightful place among research traditions, it also supports the notion of *whakapapa* research methodology throughout the indigenous world (Smith, G.H.2000).

A Western Critique of Gout

The first written description of gout dates from 2,600 BC, when Egyptians noted gouty arthritis of the big toe. Around 400 BC, the Greek physician Hippocrates also commented on gout. Writing ca. 30 AD, Aulus Cornelius Celsus appeared to recognize many of the features of gout, including its link with a urinary solute, late onset in women, linkage with alcohol, and perhaps even prevention by dairy products. Around 200 AD, the Roman gladiatorial surgeon Galen described gout as a discharge of the four humors of the body in unbalanced amounts into the joints. The word "gout" was initially used by Randolphus of Bocking, around 1200 AD. It is derived from the Latin word "gutta", meaning "a drop" (of liquid). The ancient Egyptian medical practitioner Imhotep observed gout as early as 2640BCE (Schwartz, 2006), it was also described several centuries later by the Greek physician Hypocrates (400BCE), the father of modern medicine, who referred to it as podagara, or “the unwalkable disease” (Nuki, G., Simkin, P.A.2006). The Dutch scientist Antonie Van Leeuwenhoek described the microscopic appearance of urate crystals in 1679. In 1848 English physician Alfred Baring Garrod realised that excess uric acid in the blood was the cause of gout.

Gout historically is due not only to its enduring incidence but also to its prevalence among the wealthy and those of high society. Several kings and notable historical figures are included in the cadre of sufferers: from Alexander the great, to Henry VIII, Christopher Columbus, Leonardo DaVinci, Isaac Newton, and Benjamin Franklin. The pedigree of sufferers often led to the erroneous notion that gout was a natural and unavoidable affliction of high breeding that correlated with a person’s level of intelligence. Despite this belief, it did not escape observation that it was the lifestyle rather than the pedigree of the rich that was the likely cause for the disease. In fact, it was often said that gout was a punishment. Sydenham, T. (1963) indicates gout as:

> *“old men…after passing the best part of their life in ease and comfort, indulging freely in high living, wine and other generous drinks.”*

Historical treatments for gout include gin and numerous medications that have since been found to be not effective. It was known as "The Disease of Kings" or "Rich man's disease".

Gout is no longer restricted to the circles of affluent society. In fact, the striking increase in the number of gout sufferers across the full range of socioeconomic groups highlights the emergence of gout as a common disease in western society and has seen the prevalence of gout rising in many populations. The increase has been attributed to various influences including diet and lifestyle, medical care and increased longevity. Gout in the US increased from 2.9/1000 in 1990 to 5.2/1000 in 1999 (Wallace, K.L., et al., 2004). Another based on research in England during the same period, placed prevalence at 9.5/1000 (Harris, R., et al., 1995). In the United States, gout is twice as prevalent in African American males as it is in European-Americans. Gout among the Taiwanese aboriginal populations are also high, in particular the Atayal, Bunun and Paiwan aboriginal adult populations exhibit high rates of gout (Chang, S.J., et al., 1997). Consistent with worldwide trends, gout is the most common form of inflammatory arthritis in men over the age of forty in New Zealand and is particularly common in Māori and Pacific Island populations. The most recent study recording the prevalence of gout in New Zealand was published by Klemp et al., 1997 to determine the prevalence of hyperuricemia and gout in New Zealand Māori and Europeans compared to previous published articles relating to these groups. Prior to this, there has been no epidemiological studies of gout in New Zealand since the writings of Rose, B., et al., (1968) or in Māori since 1978 by Brauer, G., Prior, I.A.M. As a result of these publications one is able to observe a general trend of increasing prevalence of gout in New Zealand over the last fifty years (Wyeth, E.H. 2007: 111).

Māori and Gout

In 1769, Sir Joseph Banks a trained naturalist onboard Captain Cook Endeavour, recorded Māori had very sound health. Banks was very familiar with gout and did not record the occurrence of gout or any other rheumatic disease during these encounters. In 1880, Newman stated in an address to the Wellington Philosophical Society that, "*rheumatism in all its forms, consumptions and scrofula were common and made particular mention that no genuine old Māori ever had gout.*" It was not until 1902, sixteen percent (16%) of cases were recorded in Rotorua were recorded with gout. It was also recorded that two Māori patients exhibited tophi; this was the earliest reporting of gout in any Māori patient (Leanne, G.A.Q., et al., 1960).

By the mid 1900's it was widely believed that gout was rare among indigenous populations throughout the world. A recent study of remains from a 3000 year old Lapita cemetery site in Vanuatu suggests the possible presence of gouty arthritis in members of the Melanesian population. This study may provide some evidence that historic Polynesian populations did actually suffer from gout, and what is known seafood and other marine resources contribute to a purine-rich diet that influences gout attacks. If this were the case, then genetic susceptibility traits have been passed down through generation and may contribute to the high prevalence of gout now seen in the modern-day Māori population, however this does not support the hypothesis that the prevalence of gout in Māori populations used to be relatively rare.

Brauer, G., Prior, I.A.M. (1978) study was the most recently published epidemiological study that investigated gout in both Māori men and women. The surveys recorded information relating to hyperuricemia and gout in Māori male and females in 1962/63, 1968/69 and 1974. The results recorded for the prevalence of hyperuricemia in males was forty-nine percent (49%) and forty-two percent (42%) in females, the prevalence of gout in males was eight point eight percent (8.8%) and in females zero point eight percent (0.8%). The authors also carried out an incidence in a Māori cohort who did not initially present with gout were re-examined eleven years later. Inflammation of the big toe was reported in ten point three percent (10.3%) of males and in four point three percent (4.3%) of females. The risk factors for gout common to both male and female were weight, height, body mass, blood pressure, and age was recorded as a risk factor only for females.

The Serum Uric Acid (SUA) level was observed to be the most important predictor of gout. The authors reported that these findings had important implications for the determination of discriminative value for hyperuricemia for both male and female Māori. Furthermore, they support the previous suggestions from Rose, G.A.Q., et al. (1968) that a single SUA of 0.48 mmol/L would be of more value and provide a more effective measure for gout and hyperuricemia intervention programmes in this population. During the course of this study a high incidence rate of gout was recorded; 37% in females with SUA above 0.48 mmol/L, suggesting the occurrence of gout is more dependent on SUA levels than other factors such as gender.

Lennane, B., et al (1960) provided two detailed studies carried out from 1956-1958 recording the prevalence of rheumatic diseases among Māori. The first survey was carried out in the Whānau-a-Apanui Iwi, nineteen percent (19%) of participants complained of rheumatism and of these, twenty-two percent (22%), (18 men and 4 women) were found to be suffering from clinical gout and a further 3 with hyperuricemia possibly had gout. The total prevalence of gout in this survey was four point seven percent (4.7%).

The second survey reported by Leanne, B., et al. (1960) was carried out during 1957/58 in Rotorua, a random sample of Māori and non-Māori adults in Rotorua. The total participants interviewed, forty-three point seven percent (43.7%) complained of rheumatic symptoms and were subsequently clinically examined for a confirmed diagnosis. Only two gout cases in the non-Māori cohort (male) were confirmed, while in the Māori cohort (male) five cases were confirmed. All seven patients with gout had elevated Serum Uric Acid (SUA), the total prevalence of gout in the Māori cohort was two point seven percent (2.7%). As a result of the surveys by Lennane, B., et al (1960), it was found intermarriage had a high susceptibility to gout, suggesting that although clinical gout was not earlier reported, Māori probably have always been predisposed in some way to this disease. Due to the lack of reporting of gout among Māori by early European settlers this may have been in part due to under-diagnosis and the huge difference in prevalence rates seen in the present-day population suggesting that there has been an increase in frequency of this disease. Wyeth, E.H. (2007) suggests "this difference is due to the absence of a major genetic event causing a change in the Māori gene pool," however intermarriage, diet and cooking methods must have helped to account for this.

Pathogenesis for Gout

The Pathogenesis (whakapapa/genealogy) of gout occurs when crystals of uric acid form and precipitate on the cartilage of joints, tendons and the surrounding tissues. Uric acid is a normal component of blood serum, if the uric acid levels are high; it is more likely that the forming of crystals will occur when there is hyperuricemia. The urate produced daily is excreted by the kidneys and the rest is through the intestines. Gout is a disease hallmarked by elevated levels of uric acid in the bloodstream. It is marked by transient painful attacks of acute arthritis initiated by crystallization of urates within and about the joints and can eventually lead to chronic gouty arthritis and the deposition of masses of urates in joints and other sites, sometimes creating tophi.

Gout is characterized by excruciating, sudden, unexpected, burning pain, as well as swelling, redness, warmth, and stiffness in the affected foot. This occurs most commonly in the toes of men but can appear in other parts of the body and affect women as well. Low-grade fever may also occur. The patient usually suffers from two sources of pain: The crystals inside the joint cause intense pain whenever the affected area is moved. The inflammation of the tissues around the joint also causes the skin to be swollen, tender and sore if it is even slightly touched. For example, a blanket or even the lightest sheet draped over the affected area can cause extreme pain.

Gout usually attacks the big toe (approximately 75% of first attacks); however, it also can affect other joints, such as the ankle, heel, instep, knee, wrist, elbow, fingers, or spine. In some cases, the condition may appear in the joints of small toes that have become immobile due to impact injury earlier in life; the resulting poor blood circulation can lead to gout. Patients with long-standing hyperuricemia can have uric acid crystal deposits called *tophi* in other tissues such as the helix of the ear. Elevated levels of uric acid in the urine can lead to uric-acid crystals precipitating in the kidneys or bladder, forming uric-acid kidney stones.

The research studies undertaken by Choi, H.K., et al. (2004 and 2006*)* indicated the serum level of uric acid is the primary risk factor for gout. The serum level is the result of both intake (diet) and output (excretion). Diet should be low fat and low protein. Furthermore, animal flesh sources of purine (such as beef and seafood) greatly increase the risk of developing gout. However, high-purine vegetable sources (such as asparagus, cauliflower, spinach, and green peas) do not. Dairy products such as milk and cheese significantly reduce the chances of gout. The study followed over 40,000 men over a period of 12 years, in which 1,300 cases of gout were reported. It was also reported that vitamin C prevented outbreaks of gout. The study, published in the March 9, 2009, issue of Archives of Internal Medicine, showed that men who had the highest vitamin C intake or higher per day had a lower risk of gout than those with the lowest daily intake per day.

Over many centuries there have been many writings on gout, as noted previously in throughout this chapter. What is clear is the imprint of the medical model featuring as the only intervention available focussing primarily on a cure or prevention, if any, and reach a conclusion to administer medication. Today Māori are still faced with the burden of a disease that has had crippling affects among the whānau, such as job losses, losing whānau members, harbouring burdens. The call for more community education and ways of engaging Māori communities has been a focus within the Counties Manukau District Health Board Māori communities in addressing gout.

Māori and Clinical Perspectives on Gout

This section investigates systems thinking within the two worlds of *raranga* (weaving process). Each woven piece connects with each other, each piece has a place in the *raranga* (weaving process), each woven piece having an integral part to the overall result. So too is the system thinking within the two worldviews demonstrating the intertwining of the two schools of thought, its integral components of connection, each level of thought contributing to the process of knowledge, and each complimenting each other. Durie, M.H. (1985) article ‘understanding health and illness demonstrates how the incorporation of indigenous beliefs into research protocols and measurements can enhance health research and understanding of health and illness. Dual paradigm - an integrated approach embracing western and Māori paradigms of thinking to transform Health services toward caring for others is the basis of discussion.

Māori Knowledge Systems

In the classical Māori society, all communication was oral and this included the handing down of tribal knowledge in the form of traditions, genealogy and mythology from generation to generation. Bishop R., Glynn, T. (1999) describes the pre European system as “pre-existing and complex and that colonisation sought to deny or belittle the existence of such a system”. Māori had a powerful knowledge base, a complex oral tradition and a dynamic ability to respond to new challenges and changing needs. These systems were important to the development of the *whānau* (family), *hapu* (sub-tribe) and *iwi* (tribe) in aspects relating to social, economic and political stability.

Leedy, P. (1997) indicates in his writings that Rousseau in the eighteenth century saw education as a lifelong learning experience, which began in childhood and continued throughout life itself. It can be seen that this pre European system of education while complex and diverse was also fully integrated into every level of Māori society in that, skills, teaching and learning was absorbed and approved through a knowledge base which linked together skills, reasoning and knowledge often through specific rituals.

Potaka, H. (1994) agrees with Rousseau that knowledge and learning was transmitted throughout the whānau, hapu and Iwi as a lifelong process. Whilst Smith (1993) emphasises the interrelationship of teaching and learning stating that to the Māori these were not separate concepts.

Bishop, R., Glynn, T. (1992) in their writings explain how Māori placed significant value on transmitted facts and beliefs which reflected a high cultural value. Transmission involved a great deal of time and repetition and was fostered within the social context of underlying principles of the culture such as mana, tapu, noa and mauri. Furthermore, Marsden (2003) suggests the world of Māori cosmogony providing interrelated topics of knowledge that provide sanctions, protocols and guidelines through Māori worldviews and value systems. It portrays an understanding of a holistic approach and the fundamental principles of Māori customs to everyday life that is integrated into the value systems of the culture.

Bird, L., et al.(2000) provides more underlying principles in Māori development by explaining how traditional Māori values work together to inscribe a total ecology or cultural environment, where all aspects are interdependent upon all other aspects. These are deeply underpinned by values of wairua (spirituality), manaaki (care for others) and whānaungatanga (maintaining the family) that are kept alive in rituals, stories and everyday contexts such as greetings.

It was clear from the writers above that there was a sophisticated and functional system for Māori that consisted of a powerful knowledge base, complex oral traditions, rituals and Māori worldviews that reflected the interconnectedness of the various aspects of health and development underpinned by values of wairua (spiritual), manaaki (care for others) and whānaungatanga (maintaining the family). These values generated and transmitted Māori knowledge that contributed to Māori advancement of development for future generations.

The pre-European systems for Māori society demonstrated a sophisticated and functional system for Māori confirming development was an essential component to the well being of the *whānau* (family), *hapu* (sub-tribe) and *iwi* (tribe). The significant period of colonisation, development implied the decline of the Māori world and its replacement by modern western systems that implemented through the policy of assimilation. This period provided European justification for the suppression of Māori rights. The writings of Buck, in ‘The Coming of the Māori’ and Ngata in ‘Nga Moteatea’ showed that Māori were versatile in adapting to the changing climate, but still wanting to develop themselves with the system of pre-European. However, Māori efforts to articulate Māori paradigms as they relate to development, noted that Māori have utilised customary conceptual frameworks and principles as the foundation for a holistic approach. It is these efforts that have managed to past the test of time, whereby Māori have continued utilising their systems that best serve the people towards wellbeing.

The Assimilation of One System

From the arrival of the missionaries, Walker, 1985, cited in Selby .R. (1999) they were seen as the party to cultural invasion and had two pronged goals; one was to convert Māori to Christianity and the other was to transform Māori from barbarism to civilized life. It was during the period of 1830’s to mid 1840’s that the Māori seized upon literacy primarily taught by the missionaries with eagerness. Selby, R. (1999) verify this by suggesting in the early 1840’s a cautious estimate might be over half of the adult population could read and write a little in their language. Within their own cultural setting it is obvious that Māori had an innate desire to acquire knowledge and the ability to persevere if they recognised that it would be beneficial to the whānau, hapu and iwi. They also had the ability to quickly absorb knowledge and share this knowledge among their hapu and iwi.

At the outset of colonisation, the then Governor Fitzroy signalled the colonial policy of assimilation. Parker, E., et al. (2003) informs Fitzroy’s preamble to the Native Trust Ordinance that assimilation should take place as speedily as possible in order to accelerate the process of settlement. Each successive education administration beginning in 1847 with the Education Ordinance Act rigorously pursued this policy. This policy continued into the twentieth century and was dominated by a belief that assimilation was a desirable outcome for the new colony. Bishop, R., Glynn, T. (1999) indicate that central Governments agenda and polices created and maintained a burden on Māori people to subjugate their own identity and destiny to the goals of the emerging nation, these goals were decided by the pakeha majority.

According to Hauora (1998) as a result of forced assimilation into the dominant culture practices that had originally been foreign to Māori resulted in Māori people having to act outside of the essential being of who they were as Māori. This policy was known as ‘the doctrine of assimilation’ that did not take long for the doctrine of assimilation to marginalise Māori language, traditions and health practices.

Furthermore, Durie, M.H. (1997) states in a keynote address to the 22 Annual Conference of the Australian and New Zealand College of Mental Health that the greatest impact to the organisation of Māori knowledge and understanding occurred in 1907 when the Tohunga Suppression Act was passed. By outlawing traditional healers, the Act opposed Māori methodologies and the legitimacy of Māori knowledge in respect of healing the environment, the arts and the link between the spiritual and secular. Dr. Pita Sharples concurs with Durie that this particular Act not only outlawed Māori knowledge but also devalued Māori knowledge. He further stated it is equivalent to saying every associate professor, every bishop and archdeacon, every secondary school principal and deputy principal will now shut up, all their information on computers will be destroyed and books burnt (McQueen, H.1993). Through this Act it made illegal the passing on of the knowledge held by the 'intellectuals' of Māori society, Māori experts or specialists regarding their expert knowledge base was outlawed, meaning tohunga practice or passing on of traditional knowledge was forbidden by law

Friere, P. (1998) stated that domination was accomplished by undermining Māori spiritual beliefs and practices. To non-Māori, culture and knowledge was irrelevant, therefore valueless in the new society and was viewed in national interest to give it credence allowing repeated Acts of parliament to undermine and devalue Māori knowledge, language and culture.

The story of New Zealand has more often than not been a vindication of progress, whereby development implied the decline of the Māori world and its replacement by modern western systems to allow for New Zealand's place in the South Pacific. In making progress the central theme in New Zealand's history, Europeans provided ideological justification for the suppression of Māori rights, for the transfer of land from Māori to European control and for an active policy of assimilation. This view is supported by Simon, J. (1992) that states the arrival of the missionaries systematically disempowered the Māori people, programming them towards limited aspirations and achievement of limited goals, the school system was designed to provide industrial type training rather that intellectual development.

The Decades of Māori Development

The 1961 Hunn Report highlighted widespread disparities between Māori and other New Zealanders. The relative disadvantage experienced by Māori, and a lack of control over their own affairs as a result of the perpetuation of historical injustices, alongside the growing momentum of social movements worldwide, provided the backdrop for Māori political activism movements of the 1960s and 1970s.

These movements have been recorded throughout this time period and the writings of Poata-Smith, E.S.T.A. (1996), on the trade union movement in the late 1960s, served to politicise Māori workers who sought improved wages and working conditions. The cause was of particular relevance to Māori, given that the Māori workforce was concentrated in unskilled labour, the most threatened sector of the labour market. Māori activist groups and the Māori Organisation on Human Rights were closely connected to the trade union movement. Māori were also actively involved in the anti-racist organisation 'Halt All Racist Tours' (HART) which was formed in 1969 and opposed apartheid. HART sought to stop the 1981 South African national rugby team's tour of New Zealand.

Walker, R. (1990) writings of Māori activists politicised through their involvement with a variety of movements that formed their own groups specifically committed to the advancement of Māori that emphasised working within existing systems, while others considered existing systems unworkable and, therefore, that Māori issues could only be addressed through the adoption of new systems. The Māori activist group Nga Tamatoa became the 'public face' of Māori activism during the 1970s. Nga Tamatoa was involved in a range of activities including monitoring the courts, campaigning for the inclusion of the Māori language in school curriculum, and introducing a Māori language day, which eventually became Māori language week.

Durie, M., 1998b, and Walker, R. 1990 provided accounts of key protests of the 1970s, the 1975 land march, the Bastion Point protest, and Waitangi Day protests. The 1975 land march on parliament to petition the Government in regard to unjust Māori land alienation drew 5,000 protestors, and more than 60,000 people signed the petition. The late Dame Whina Cooper, founding president of the Māori Women's Welfare League, led the march.

In 1977, the Orakei Māori Committee Action Group demonstrated its concern over the Government's lack of action in relation to Ngati Whatua, Orakei land claims, by rallying support and establishing a camp on Crown land at Bastion Point. The Bastion Point protest attracted many supporters who, though not necessarily connected to the specific purpose of the protest, shared the general concerns of the Orakei Group. The protest lasted 506 days and when it was finally ended, with the serving of an eviction notice and a force of 600 police officers and army personnel, 222 people were arrested. Regular protests at the Waitangi Day celebrations in Waitangi (to mark the signing of the Treaty of Waitangi) began in the early 1980s and have continued up to, and including, the present day.

Māori political activism of the 1960s and 1970s, though often centred on land and natural resource issues, was an expression of growing Māori discontent with the marginalisation of Māori in all areas. Activists called for the recognition of Māori aspirations, redressing of historical injustices that continued to disadvantage Māori people, honouring of the Treaty of Waitangi, equitable allocation of resources, and Māori advancement generally. Activists were committed to the position that Māori should lead their own development and that distinctly Māori approaches to development were valid and should underpin strategies for Māori advancement.

The decade of Māori development saw the momentum of the Māori political activism of the 1960s and 1970s crystallise into a higher Māori profile within State institutions, increased representation of Māori within parliament and a range of distinctly Māori initiatives across sectors. This decade can be considered as a reference point for contemporary Māori development.

Durie, M. (1998b) suggested Māori political activism of the 1960s and 1970s was the foundation on which a more consistent approach to Māori advancement was built. That approach has been labelled self-determination, and/or Māori development. Some commentators distinguish between self-determination and Māori development on the grounds that, while both approaches seek to facilitate Māori advancement, the mechanisms differ. Self-determination emphasises Māori control of resources and autonomy from the State, while Māori development can include a prominent role for the State.

Māori Models of Health

The Massey University, Department of Māori Studies, Palmerston, New Zealand, (1994) suggests the concept of Māori development was given increased prominence at the 1984 Hui Taumata (the Māori Economic Summit), through the launching of the Decade of Māori Development (1984-1994). Hui participants included both tribal and Māori community representatives. The major objectives of the Hui were:

- To reach an understanding of the nature and extent of the economic problems facing New Zealand as they affect Māori people;
- To examine the strengths and weaknesses of the Māori people in the current position;
- To discuss policies for Māori equality in the economic and social life of New Zealand; and,
- To obtain commitment to advancing Māori interests

Durie, M. (1998b) identified six general themes that emerged from the hui and that can be considered as a basis for the Decade of Māori Development: the Treaty of Waitangi, Tino Rangātiratanga (self-determination), tribal development, economic self-reliance, social equity, and cultural advancement. Māori community development is also accepted, alongside tribal development, as central to Māori advancement, (Tamihere, J.1999).

Durie, M. (1998b) suggested the decade of Māori development expressed Māori confidence in distinctly Māori approaches, and was premised upon the sentiment that Māori advancement would rely upon “Māori solutions to Māori problems”. Loomis, T. (2000a: 12) suggests that, based on overseas experience, the Government should be primarily concerned with supporting Māori capacity building.

> *“Capacity building, at least in overseas experience, emphasises indigenous autonomy and self-determination, of ownership of resources and control over decision-making. Its main focus is on strengthening governance, human capital and infrastructure so indigenous people can govern themselves and determine their own path of development.”*

Ratima, M. (2001), states that Māori customary knowledge and understanding founded on tribal values, beliefs and custom presents a recognisable philosophical base. Today, it is cultivated in the discourse of Māori realities revealed by concepts such as whakapapa (genealogy), whānaungatanga (relationships) and mauri (life source). This framework for Māori development is supported by Loomis, T. (2000b) “Māori efforts to articulate Māori paradigms as they relate to development, note that Māori have utilised customary conceptual frameworks and principles as the foundation for a holistic approach.”

While there has not yet been a comprehensive articulation of Māori paradigms, there is some consensus among Māori development academics that there are distinctly Māori worldviews, and that although they are implicit they underpin Māori development theory and practice, and have an integrated nature (Loomis, T. 2000b; Puketapu, B.T.T. 2000; Walker, R.1990).

Cultural advancement has been identified as one of the themes of the Decade of Māori Development (Durie, M. 1994b). Cultural advancement relies upon access to Māori resources (Durie, M., et al., 1995). Increased access to Māori resources will require the protection, enhancement, and management of those resources as well as greater opportunities within New Zealand society for Māori cultural expression.

Contemporary Māori development has emerged from within, as a Māori-driven process to realise Māori self-determination and advancement. The decade of Māori development is a reference point for the enhancement of contemporary Māori development. Māori development is centred on people, rather than having a sole focus on economic growth. A distinctive feature of Māori development is that it is grounded on Māori worldviews and therefore, draws on customary knowledge. Ratima (2001) suggests Māori concepts of health place a greater emphasis on holistic and are consistent with those of other indigenous peoples.

Indigenous Knowledge

Indigenous knowledge cannot be verified by scientific criteria nor can science be adequately assessed according to the tenets of indigenous knowledge. Each is built on distinctive philosophies, methodologies, and criteria, (Durie, M.1985). While there is considerable debate around their relative merits, contests about the validities of the two systems tend to serve as distractions from explorations of the interface, and the subsequent opportunities for creating new knowledge that reflects the dual persuasions. It is not unusual for scientists or indigenous peoples to live comfortably with the contradictions of different bodies of knowledge. Many scientists subscribe to religious beliefs that cannot be explained by science, and many indigenous people use scientific principles and methods in everyday life while at the same time holding fast to indigenous values. Rather than contesting relative validities, there are an increasing number of indigenous researchers who use the interface between science and indigenous knowledge (Durie, M. 2004), as a source of inventiveness. They have access to both systems and use the insights and methods of one to enhance the other. In this approach, the focus shifts from proving the superiority of one system over another to identifying opportunities for combining both.

Indigenous knowledge refers to the unique, traditional, local knowledge existing within and developed around the specific conditions of people indigenous to a particular geographical area. Indigenous knowledge systems cover all aspects of life and applied in all disciplines. These traditional knowledge systems according to Chavunduka (1999:1) are:

> *"Cumulative, representing generations of experiences, careful observations, and trial and error experiments, these systems are dynamic; new knowledge is continuously added."*

Modern science is a product of western culture and as a system it has tried, with some success in certain areas, to destroy or exclude other forms of knowing. In many indigenous countries the introduction of modern science had much wider motives and objectives than the advancement of knowledge. Science has come to many indigenous countries as a knowledge system of colonial forces and as an ally of Christian faith. Modern science was at times used to denigrate people and to castigate them as ignorant and superstitions. The modern science and technology fought and displaced indigenous knowledge systems and negatively interfere with the long term established indigenous cultural values. Fanon, F. (1963) states:

> *"Japan was able to accept Westernisation on its terms, as its own speed and with its own reservations, ensuring as far as possible that new technology and organisation were assimilated by Japanese thinkers and teachers without dishonour to ancestral shrines and gods. Japanese self-confidence was salvaged."*

However this was not the same many indigenous countries such as African American the Land Husbandry Act 1951, was largely used to change African image and values about land. To protect and promote western medical knowledge and medicines attempts were made to suppress the African medical knowledge and medicines.

Colonial attitudes and a number of measures were adopted to weaken indigenous knowledge systems and destroy practices through policies of assimilation, Christian education of European cultural backgrounds, imaginary and the use of degratory terms to describe traditional doctors of traditional medicine. The hostility between practitioners of modern traditional medicine which was promoted by colonial administrators to some degree still exists within indigenous countries. Chavunduka, G. (1999: 3) contends:

> *"A knowledge system that excludes other forms of knowing creates problems, one problem is that it narrows the horizon of many scientists and other thinkers; it limits their potential resources of knowledge. There is a vast sea of knowledge which awaits our exploration, articulation and use.*

Indigenous peoples and 'States' have fought in a variety of contexts most obviously around territorial lands, waterways and oceans. While these contests have generated significant debate there has been a continuous shift from this position and a shift into intellectual and cultural sites. Whilst indigenous knowledge and science argue the validity of each others paradigms, there is still a school of thought that both can co-exist as recognised knowledge systems as opposed to being either misinterpreted or misrepresented as a viable source of system bound knowledge.

Science is recognised as a dominant global knowledge system and has often been accused of being intolerable towards other persuasions. Science has a fundamental premise that if empirical evidence is not supported by evidence based practice or inability to replicate results or the conclusions are not supported by this empirical evidence therefore creating doubt in the validity of such information. Much has been written in regards to systems of knowledge that do not subscribe to scientific principles, particularly where it is situated in regards to its status i.e. considered a lesser position or status or as the final insult rationalised according to scientific principles therefore suggesting a context which has been positioned out of context with the remaining parent knowledge system.

One of those paradoxical contexts is created in reverse in that indigenous knowledge also dismisses science as a legitimate knowledge base as it appears that science does not have the capacity for explaining spiritual phenomena or recognising the existence of nature as a viable construct. Science will consider the analysis of smaller components as a standard scientific method whereas indigenous knowledge accommodates the potential of construction of broader modalities with multiple strands incorporated into the whole.

Indigenous and science disregard and mistrust of one another has created a context of limitation on each other, as this suggests, that both consider each other using a reduced framework and reduced capacities or criteria. In this context it would be deemed inappropriate for either indigenous or science to use each others own tools of analysis on the other as each represents a body of knowledge in its own right.

A Dual Paradigm Approach: An Interface of Systems

There are attempts now being made by scientists and other theorists to take a serious view of indigenous knowledge. Michael Warren in 1997[7] in a paper presented at a conference in Italy and showed the number of published case studies of indigenous knowledge in a growing number of disciplines is increasing. He listed 38 disciplines and 125 publications to demonstrate successful fusion of indigenous knowledge and science. A holistic approach which has always been the basis of indigenous knowledge systems is been accepted by many scientists and policy makers as an alternative collective wisdom within many disciplines. As these traditional systems focussed problems on the entire systems approach, that demonstrates the linkages and complexities, many people in the field of modern western medicine are realising the importance of including the physical, spiritual, mental, family and socio-cultural of a person when considering matters of health.

Durie, M.H. (2004) in his paper understanding health and illness, illustrates research at the interface between science and indigenous knowledge, presented three case studies to illustrate how Māori health researchers in New Zealand have been able to draw on both systems in order to conduct research that has credibility in scientific and cultural terms. The first study concerns a survey of the nutritional status of children under 15 years of age, the second is about the measurement of outcomes resulting from mental health interventions, and the third demonstrates how cultural perspectives of health and wellbeing can be incorporated in research design. The first Case Study was described as follows:

> *"It involved 3000 children aged 5-14 years and contains 1000 Māori children. Māori participation was initially threatened partly because the food frequency questionnaire did not recognise indigenous foods but mainly because there was opposition to the collection of blood and urine samples. Two concerns were expressed by Māori communities. One was related to a Māori worldview that people are vulnerable if their body parts, including fluids, fall into the malicious hands.*

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[7] The Domestication of Knowledge and Practical Users. Paper presented in Venice, Italy, (2007).

> *Underlying that fear is a widespread conviction that the mistreatment of body parts including even a human shadow can result in mental or physical harm to an individual. The other was many indigenous peoples concerns of genetic modification might lead to DNA experiments on blood samples collected for other purposes. There was a lack of trust in the ability of the researchers to safeguard human property.*
>
> *The research team included a group of Māori researchers who had understanding of both qualitative and quantitative methods and had wide experience in health research with Māori people. On their advice, a Māori advisory group made up of eight elders, the kaitiaki group was established. The elders made recommendation to the research protocols by extending the food frequency questionnaire to include foods that had some special cultural value to Māori. Two elders were designated as spiritual guardians for the blood and urine. Along with the senior Māori researcher they travelled with the specimens to the laboratories and having satisfied themselves that the handling of samples was consistent with the principles of respect and dignity, conducted a ceremony to render the laboratory safe. Once analysis were completed, the blood and urine remnants were then buried in the earth, again with the approval of the elders.*
>
> *Although non-Māori members of the research team were divided about the necessity for making special arrangements for Māori blood and urine samples, after explanations about Māori worldviews and systems of knowledge, there was unanimous support and even interest in participating in the ceremonies. The changes attitudes of both the scientific and Māori communities owed much to the key roles played by Māori researchers as they worked to synchronise the interface between science and indigenous knowledge."*

In Case Study 2 the focus was on Health measurements:

> *"In response to Māori dissatisfaction with existing measures, the Māori Mental Health Outcomes (MMHO) framework was developed by Māori researchers to measure mental health outcomes for Māori. It is based on Māori perspectives of health and depends on the views of consumers, clinicians, and family who are independently asked to rate the effect of a particular intervention on wairua (spirituality), hinengaro (mental/behavioural domain), tinana (physical health), and whānau (family/social health). The underlying premise in the framework is that wellness, not simply the removal of symptoms, should be the aim of an intervention.*

> *While this approach is consistent with holistic framework, it sh*ould be noted *that wellness depends on many variables that can reasonably be expected of a treatment or care service. Models of disease remission focus on the signs and symptoms of disorder, rather than the capacity to function in a dignified and meaningful way. The principle of wellness reflects consumers' interest in being able to enjoy a meaningful life, with or without symptoms. Of all the domains, wairua (spirituality) is probably the most difficult to measure. In the MMHO study two approaches have been taken to measure spirituality. The first asks whether, as a result of a particular intervention, consumers have become stronger as a Māori and responses are rated on a five-point scale. The second is more concerned with feeling valued and healthier from a spiritual point of view. Clinical trials are encouraging enough to suggest that the measure, constructed around Māori perspectives of health, will provide a useful outcome measurement tool."*

In Case Study 3 Health perspectives; the Kaumatua story

> *"A survey of 400 Māori participants over the age of 60 years undertaken by Māori researchers in 1996 assessed standards of health and wellbeing. The assessment was based on Māori health perspectives and also recognised the roles and functions of older people within Māori society. Wellbeing for older Māori was therefore contextualised as an interaction between personal health perspectives and participation in certain key elements of Māori society i.e. land, language, marae (tribal gathering places). Methods of estimating personal health were required as well as measures of the quality an quantity of interaction with Māori cultural heritage. The objective was met by using a cultural index devised in a longitudinal study of Māori households, Te Hoe Nuku Roa. The index is capable of measuring use of Māori language, access to customary lands, participation in tribal activities, and inclusion in family celebrations. It has since been used as a proxy for 'Māoriness' and has enabled correlations to be made between spirituality, cultural affinity, material wellbeing, general health status and disability.*
>
> *In the study of older Māori those participants who scored lowest on the cultural index scales were likely to have the worst health. While the relationship between the two measures is complex, older people who had lower cultural index scores, reported lower levels of wellbeing, even in the presence of similar standards of health. A Māori worldview of wellbeing is closely linked to an ability to fulfil a*

> *cultural role. Measures of wellbeing that do not capture cultural identity will not be able to convey the nature of wellbeing, as it applies to Māori."*

The interface between science and indigenous knowledge need not be a site of contest; it should provide opportunities for the expansion of knowledge and understanding. In case study one there was no attempt to fuse the two knowledge systems rather it was the integrity of each that was acknowledged and the dual contributions led to more sophisticated understandings of health research. Case studies two and three illustrated if the conceptualisation of health held by a population were not adequately appreciated and as a result created misleading conclusions. It proved problematic with some clinicians who argued that their task was not to improve spiritual or even physical health but to treat mental illness. For most of the clinicians, consumers and families welcomed the opportunity to measure outcomes using criteria that made sense to the target population. The Māori researchers who developed the instrument were able to draw on two distinct bodies of knowledge to create a measure that had scientific robustness as well as cultural validity.

Indigenous researchers have a crucial role in straddling the divide between science and indigenous knowledge, acting as agents at the interface (Durie, M. 2004:9). Indigenous people not only have access to their populations, but they also have access to two systems of knowledge and subscribe to both and they face criticism from two fronts. In case three, Māori may feel that the Māori component has simply been added on to standard scientific practice, without any fundamental shift in method. Researchers on the other hand may complain unnecessary variables have been introduced which limit cross-population studies. Māori researchers concerned have been encouraged by the possibilities that two world views, two bodies of knowledge can be brought closer together. There is recognition that in developed countries most indigenous peoples live at the interface, they are informed by science and their indigenous knowledge.

Summary

Through *whakapapa* (genealogy) history unfolds historical patterns such as health and levels of wellness (mauri ora). It is here that we find ways of working with the illness, the pathway forward and the pathway undertaken, (Patterson, J. 1992: 7). *Whakapapa* (genealogy) legitimates a Māori worldview which is at the heart of Māori knowledge, Māori ways of knowing, and Māori ways of acquiring new knowledge. It reviewed historical and current literature on the western medical model relating to and about gout. The final section is an analysis of 'systems thinking' approach within the two worldviews, (western medical model and *Te Ao Māori*). The challenge with the interface of two systems, Durie, M.

(2004:10) asserts, is to "*afford each belief system its own integrity, while developing approaches that can incorporate aspects of both and lead to innovative, greater relevance, and additional opportunities for the creation of new knowledge.*"

Chapter four continues with a dual paradigm approach embracing Māori and Western schools of thinking when supporting Māori with gout. Action research can be a powerful tool for change and improvement in health services for Māori people when utilised within an appropriate framework. This section continues with a dual approach embracing Māori and Western paradigms of thinking when supporting Māori with gout. It will illustrate the convergence in its use of kaupapa Māori research methods in its efforts to improve the health and well-being of Māori within South Auckland communities. It outlines the research processes and outcomes obtained through the application using a dual paradigm approach to understand Māori pathways and disablers when accessing health services for the disease gout. The research examines dual paradigm of Māori and Western bodies of knowledge as hoa haere (companions) sharing equal space.

Chapter Four

Dual Paradigm Methodology Approach

The focus of this research provided a framework for a cultural model, its interventions and its indicators relating to gout, using Māori methodology. Under kaupapa Māori, an ideal framework must refer to and be informed by a cultural base that will speak to Māori needs and aspirations in regards to present-day demands and conditions (Te Puni Kokiri, 1992). A philosophy that embraces new ideas, new technologies, new strategies, collective talents, expertise and energies need to be fully harnessed from across Māoridom as a whole. In this way such activities contribute to the survival, the continuity and the future development of Māori culture and identity. This was achieved using *Te Ao Māori (*Māori worldview) framework to guide the analysis in the implementation of a *whakapapa (*genealogy) model as a means to measure a paradigm shift from a medical model perspective of treating gout symptoms to *Te Ao Māori* (Māori worldview) thinking on the disease. This assisted in building an evidence base Māori methodology for Māori to better understand gout through *whakapapa* (genealogy); it was also aimed at supporting and helping medical communities come to a better understanding of Māori science.

The research methodology applied kaupapa Māori research (KMR) using a *whakapapa* (genealogy) framework; qualitative Māori centred which will be achieved by using a participatory action research approach. Smith, L.T. (2006:7) states:

> *'participatory action research, Kaupapa Māori research, oral histories, critical race theory and testimony are just some examples of methodologies that have been created as research tools that work with marginalised communities, that facilitate the expression of marginalised voices and that attempt to represent the experience of marginalisation in genuine and authentic ways'.*

The methodology was formed on the basis of *tikanga* (protocols); *tikanga* (protocols) may be defined as a way(s) of doing and thinking held by Māori to be just and correct, the right Māori way of doing things (Metge, J.2001: 1). The methodology followed the rationale of using kaupapa Māori thinking to inform and guide correct process of engagement at all levels, indicating a structure of order and a method to engage appropriately. This notion of order, Friere, P. (1998:51) asserts that without methodological rigor, there can be no right thinking. *Tikanga* (protocols) therefore provides the framework of correct engagement when working with Māori on gout. As a note, *tikanga* (protocols) vary between iwi (tribes) and their practices of engagement will follow their *kawa* (practices). A researcher should investigate further iwi specific *Tikanga* (protocols) and *Kawa* (practices) before carrying out research in the area.

A participatory action research (PAR) approach ensured active research participation and ownership by Māori. It is important that the research was carried out with Māori and not on them. It was imperative that Māori spoke of their own 'knowing' about gout and were enabled to place their own context, consequences and meaning to a cultural model, its interventions and its indicators relating to gout. It was important to ensure that Māori suffers of gout and their *whānau* (family) were engaged participates and were involved throughout the whole of the research process. The significance of their voices, perspectives and lived experiences were prioritised throughout this research. This was achieved through kaupapa Māori research using a participatory action research approach. Aspects of qualitative research was used as it is descriptive and has an emphasis on process, meaning and understanding gained through the use of words and pictures (Sarantakos, S.1993).

Kaupapa Māori Research Methodology: The investigation of gout

There is agreement amongst Māori academics, welfare and education professionals that models of analysis and intervention methodologies based on Western thinking have been consistently ineffective for Māori (eg, Grennell, P.2006, Jenkins, K., Pihama, L. 2001). This mindset among Māori is no different in the field of health and has had profound affects on the lives of Māori as a whole. The medical framework has dominated the health sector diagnosing symptoms of illnesses; unfortunately there has been little or no engagement with other indigenous cultures to connect bodies of knowledge from the medical framework of thinking with indigenous cultural frameworks working with them. This is supported by Tsai, T. (2006) who states:

> "*traditional biomedical models alone appear insufficient to explain and eliminate the health disparities in Indigenous communities ...ecological and socio*-*cultural determinants profoundly demonstrate the effects of disparities in healthcare delivery and health outcome... it is time that the nursing profession took a more active role in improving the health status of Indigenous populations."*

The medical framework addresses diagnosis matched with the symptoms, sometimes patients have multiple diagnoses making it very complex to address and achieve an outcome. For Māori the issues have been the limited acknowledgement for a holistic worldview approach of well being connecting *taha tinana* (physical being), *taha wairua* (spiritual being), *taha hinengaro* (process of thinking), with the elements of nature and must be considered when working with Māori'. This shift of thinking has been investigated by Durie, M. (1985) stating:

> *"Māori researchers in Aotearoa/New Zealand have been able to apply the methods and values of both systems in order to reach more comprehensive understandings of health and illness, demonstrating how the incorporation of indigenous beliefs into research protocols and measurements can enhance health research and understandings of health."*

KMR and participatory action research (PAR) is the ideal frameworks for this research; they both provide an emancipatory theory with its foundation in both western and Māori worldview and developed alongside the theories of other indigenous and minority groups who have sought a better deal from mainstream society (Cram, F.2006).

In order to understand what KMR approach may include it is good to see what others have identified as features in this type of research. There have been various types of KMR approaches appearing in literature reviews regarding kaupapa Māori theories and practices. It asserts a need for Māori to develop initiatives for change that are located within distinctly Māori frameworks (Jenkins, K., Pihama, L. 2001). The most commonly used definition of Kaupapa Māori is by Smith, L. (1999: 1):

> *"Related to being Māori, is connected to Māori philosophy and principles, takes for granted the validity and legitimacy of Māori and the importance of Māori language and culture, and is concerned with the struggle for autonomy over our own cultural well-being"*

Hudson, M. (2004:25) indicates methodologies that have been developed from a Māori inquiry and are distinctly Māori are referred as kaupapa Māori research. The term kaupapa Māori covers a broad range of innovative research approaches, requirements and issues relating to Māori. KMR is defined by Māori for Māori and with Māori (Smith, L.T.1995) challenging a universal approach in addressing Māori needs, as such giving full recognition of Māori culture and values systems, (Reid, P.1998). KMR has grown momentum over the years and research involving Māori knowledge and people needs to be conducted in a culturally validating way to ensure the research has benefits for Māori. The role of kaupapa Māori researchers legitimises matauranga Māori and further develops kaupapa Māori, as one part of the struggle to empower and liberate Māori people and community. The emancipatory goal of kaupapa Māori research is one of its defining features.

KMR is a philosophical framework that has emerged at least partly in response to the largely negative impact of conventional Western research on Māori. As Smith, L.T. (1999) states, "*Research was an important part of the colonisation process because it defines what legitimate knowledge is."* Colonial research has been instrumental in the development of theories that have legitimated the dispossession and dehumanising of Māori, privileging Western ways of knowing and denying Māori the validity of our knowledge, language and culture (Walker, R. 1990, Stewart, T.1997, Durie, M. 1998, Smith, L.T. 1999, Moewaka

Barnes, H. 2000). Historically, Pakeha researchers have failed to recognise the existence of cultural differences, and assumed that the *Pakeha* way of doing things is a universal norm (Metge, J. 1986, Cram, F. 2001, Nairn, R.F., et al. 2006).

The health arena has led a conventional positivist health research to questions, methodologies, methods and collection of data that have little meaning for Māori. In addition, analysis and interpretation has been processed through the filter of Western cultural assumptions, leading to a focus on negative aspects of Māori realities (Paraha, G. 1993, Teariki, C.P., et al. 1992, Jahnke, H., Taiapa, J. 2003), labelling Māori as the problem instead of adopting a more system-analytical approach (Crengle, S. 1997). It is important to remember that the things that are being researched, in terms of Māori health, are a product of the history of colonisation (Jackson, M. 1996, Cram, F. 1997, Cunningham, C., Stanley, F. 2003).

Furthermore, such research has simply been descriptive, without contributing to change. There is an expectation among Māori that research in which they participate will benefit Māori in some way (Cram, F. 1997) or even be transformational (Smith, L.T., Cram, F. 1997). Similarly, with much previous research the researcher has “owned” the information and has not been accountable to the participants or the community (Te Awekotuku, N. 1991, Cram, F. 2001, Jahnke, H., Taiapa, J. 2003).

KMR has grown as an explicitly localised response to perceptions and realities of what Russell Bishop terms ‘epistemological racism’ (Bishop, R., Glynn, T. 1999: 1). The grounding in Māori lives, from the use of Māori words and terms to the social and cultural engagement that occurs specific to Māori people and the spaces that they control, presupposes both the legitimacy of matauranga Māori and the value of Māori culture (Smith, L.1999).

By definition KMR is grounded in the lives and experiences of Māori and thus requires an application of certain investigative protocols and rules that underpins a ‘uniquely valid Māori way’. Researchers have long questioned the place of western methodology in Māori research. Smith, L.T. (1999) and Bishop, R., Glynn, T. (1999) have argued about the extent to which western research ignores Māori protocols, beliefs and values. Moreover, how western thought influences the results of research and does little to improve overall well being.

For Māori researchers working with, and among their own people, these conduct considerations should be adhered to unequivocally at all times. The distinction between Māori-driven research and Māori-based research: that the former calls into account *whakapapa* (genealogy) and *whānaungatanga* (extended family ties) connections as standard qualifiers to research. Bevan-Brown, J.[8] noted Māori research has its own set of unique criteria and this would mean “it must stem from a Māori worldview, be based on Māori epistemology and incorporate Māori concepts, knowledge, skills, experiences, attitudes, processes, customs, reo, values and beliefs.”

Pohatu, T.W. (1999) provides a truly *kaupapa Māori* (Māori philosophy) template when considering the notion of *Ata* as a behavioural and theoretical strategy employed by Māori in relationships and offers cultural definitions and interpretations of *Ata* to a transformative approach to advance ethical social service practice in Aotearoa today. *Ata is* considered as a vital cultural tool created to shape and guide understandings of relationships and well-being.[9] The endeavour to gain meaningful insights into the integrity of *Āta* and its applications has led to the constructing of the following constituents; *Ata* focuses on our relationships, negotiating boundaries, working to create and hold safe space with corresponding behaviours, it gently reminds people of how to behave when engaging in relationships with people, kaupapa and environments. In order to fully appreciate the fullness of *Ata*, Pohatu asserts, “*it should be considered individually, in this way one can experience and feel their true worth and value*.”[10] *Ata* has the potential to help guide what and how we do things, how to enter, engage and exit relationships in order to explore the deeper appreciations of its transformative potential.

These methodologies provided the rationale for using *kaupapa Māori* (Māori philosophy) thinking to inform and guide the process applied. For ‘without methodological rigor, there can be no right thinking (Friere, P.1998:51). The *Ata* framework assists and marks; the placing of *takepu* or Māori principles that identifies, defines, positions and verifies *Ata* in every aspect of activities; Cultural purposes and reasoning as shaped by Māori thought and thus constructed and articulated by *Ata*. A place for Māori to safely bring forward definitions and their ways of informing activities; Energy that can be traced in our activities and practice at every level, as individuals or groups work to fulfil cultural responsibilities. ‘*Ata*’ is very useful as a tool to assist in informing and shaping ‘good’ Māori activities and practice. Knowledge and wisdom is a pre-requisite for the development and wellbeing of future generations. Māori cultural signposts and messages that should be validated and re-validated throughout the generations is *kaupapa* Māori. The model *Ata*, to hold levels of insights and possibilities that can be reshaped and used to promote positive Māori behaviour and practice.

Kaupapa Māori is the development of philosophies and frameworks that inform our work and that are distinctively Māori. It is not only an academic exercise but is a process of

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[8] Bevan-Brown, J. By Maori, for Maori, About Maori – Is that enough? In Te Ohu Rangahau: Maori Research and Development Conference Proceedings 1998. Maori Studies Department, Massey University, Palmerston North.

[9] Ibid: 2-6

[10] Ibid: 2-6

drawing upon those foundations of Māori knowledge that enhance the possibilities for our people. As such, the positioning of Māori academics and others who argue that Kaupapa Māori is a basis from which we affirm te reo and tikanga Māori as having vast knowledge from which we can draw upon to make changes. KMR locates Māori understandings as central to the research design, process, analysis and intended outcomes. Kaupapa Māori theory is a framework for enabling us to theorise and practice Māori research that validates Māori knowledge, Te Reo Māori me ona tikanga, and the multiple Māori ways of doing things and for designing interventions that can make a positive improvement for Māori people.

KMR provides for distinctive cultural methodological developments. This is argued by Dr Linda Tuhiwai Smith (1996) stating "*The concept of kaupapa implies a way of framing and structuring how we think about those ideas and practices"*. An example of a *kaupapa* framed intervention practice is *kura kaupapa* Māori (Māori primary-intermediate school). One of the key elements is that the development originated from and is driven by Māori and Dr. Smith argues that key elements within Kaupapa Māori theory are

> *"The validity and legitimacy of Māori is taken for granted, the survival and revival of Māori language and culture is imperative, the struggle for autonomy over our own cultural well-being, and over our own lives is vital to Māori survival. These features speak not to content per se, but to Māori aspirations, philosophies, processes and pedagogies, which are consistently found within successful Māori interventions".*

The basis of this research provides processes by Māori for Māori framed by and within Māori understandings and approaches. The approach does not exclude the use of a wide range of methods but rather signals the interrogation of methods in relation to tikanga Māori, (Smith, L.T. & Cram, F, 1997).

A kaupapa Māori approach using w*hakapapa* (genealogy) is another signal to inform methodology in several different ways when working with Māori. It may incorporate approaches which assist engagement and participation, trust, identity, relationships, belonging and connectedness. It is through *whakapapa* (genealogy) that the organisation of knowledge of all things legitimates a Māori worldview, which is at the heart of Māori knowledge, Māori ways of knowing and Māori ways of acquiring new knowledge. Accordingly, a research methodology framed by *whakapapa* (genealogy) not only authenticates Māori epistemology and its rightful place among research traditions, it also supports the notion of *whakapapa* (genealogy) research methodology. Furthermore Durie, A (1998: 257) states this process as:

> *“Māori in former times used whare Wānanga, these were institutes of higher learning carrying major responsibilities in the retention and transmission of knowledge, debate will occur over particular aspects of knowledge. Research in the sense of a hypothesis, problem posing, enquiry, explanation, within the bounds of particular philosophies of knowledge, ways of knowing, and accepted methodologies through which knowledge and ideas could be examined.”*

It is through *whakapapa* (genealogy) that individuals attended these institutes, with emphasis on transmitting Māori bodies of knowledge to ensure the best health outcome for the *iwi* (tribe). The significance of applying *whakapapa (genealogy)* as a research methodology is the belief that links everything in this world from a *whakapapa* (genealogy) continuum, connecting to everything and everyone. These links are part of an ever-widening cycle of relationships where information is continually being transmitted and received. It encompasses all living things from the gods to the present time, everything has *whakapapa* (genealogy), a genesis, and it is through *whakapapa* (genealogy) that kinship and economic ties are cemented and hold knowledge, and great efforts are made to preserve it. *Whakapapa* (genealogy) is the basis of all knowledge and every effort is made to preserve it, as noted by Buck, T.H. (1949:433) stating the significance of *whakapapa* (genealogy):

> “*Learning comprises of sequential ordering of the phenomena of nature before arriving at a genealogical table of human descent and saw such action as providing an opportunity for the expert to add length and prestige to the human line of descent.”*

Whakapapa (genealogy) identifies who one is, where they come from and in doing so identifies a place that they call *turangawaewae* (place of standing). The significance of *whakapapa* (genealogy) knowledge giving an individual or collective a sense of purpose, a sense of meaning, a sense of ‘being’ and grounds us back to our *whenua* (land). Māori traditions have their origins traced back to creation of the universe that has been passed through generation to generation through *whakapapa* (genealogy) recital, *waiata moteatea (*traditional songs), *purakau* (stories/ballad) and these forms of methods have played an important function in *matauranga Māori* (Māori knowledge) transmissions. Durie, M. (1998:144) states “*narratives relating to the creation traditions are effectively representative of the genesis of Māori thought,”* and through this process guides and informs ways of articulating, expanding, elaborating, and synthesizing knowledge. Māori traditional oral narratives in the form of *waiata* (songs), described the formation of the universe in a language and framework based on *whakapapa* or genealogical descent that brought congruent forms of life together, engendering new life form (Royal, C. 2003). These interactions eventually materialised as a lattice of relationships connecting people and places; and were invigorated by mutual exchanges as Salmond, A. (1997:401) states where “*tapu*, or cosmic power, was the source of all creation bringing together complementary forms of life, generating new beings."

Whakapapa (genealogy) begins with understanding that knowledge emerges from within a worldview and is interconnected with the spiritual, human and physical world that are fundamental features of a Māori worldview that forms the basis of a Māori epistemology. Knowledge development is a dynamic and organic process in which learner and learned interact within a whakapapa framework that is as defined and specialised or as broad and encompassing as one chooses. *Whakapapa* (genealogy) methodology informs and is applied to areas including research, knowledge generation and creative processes. It becomes the most fundamental aspect of the way Māori think about and come to know the world (King, M.1981), it is acknowledged as a way of thinking, a way of storing knowledge and a way of debating knowledge (Smith, L.T.1999), a means and way to acquire new knowledge.

The concept of *whakapapa* (genealogy) is consequently the all-inclusive interweaving mechanism that provides a legitimate foundation from which Māori research can be conducted and validated today. It provides the space for Māori knowledge and is a means of considering the world thereby separating Māori-centred research from Western research perspectives. Royal, C. (1998:4) in developing Te Ao Marama: A research paradigm, illustrated its strength as a medium from which the past is drawn upon to enthuse contemporary Māori theorising and philosophical reflection. In doing so, whakapapa was identified as an analytical tool traditionally used by Māori to understand:

> *"the nature of phenomena, the origin of phenomena, the connections and relationships to other phenomena, describing trends in phenomena, locating phenomena and extrapolating and predicting future phenomena."*

In order to explain the presence of a phenomenon, a process of understanding how that particular phenomenon came to exist? How did it come about and what was responsible for its presence? Once these questions are answered, then this same process can be repeated at this new level and at preceding levels until such the researcher has attained the objectives applicable to this analytical process. An important aspect of this research paradigm is the prediction of future phenomena and so, of particular interest is the observation that *whakapapa* (genealogy) as a research methodology is seen to be organic rather than deconstructive. While *whakapapa* (genealogy) allows Māori to trace their descent back through the generations, *whakapapa* (genealogy) also permits movement and growth into the future, (Smith, G.H.2010:3).

Participatory Action Research Methodologies

The traditions of participatory action research (PAR) have influenced the field (Wallerstein, N., et al.2003): the earlier northern action research tradition of Lewin (1948) organizational change action and/or reflection cycle from the 40s and 50s; and the southern 1970s participatory research tradition, with academics from Asia, Africa, and Latin America challenging their roles in the academy and their responsibility to transform inequitable conditions in society (Fals-Borda, O. 2001; Fals-Borda, O., Rahman, M.A. 1991). Over recent years, recognition of synthetic definitions and principles of Community Based Participatory Research (CBPR) has been increasing steadily through new books (Blumenthal, D.S., DiClemente, R.J. 2004; Israel, B.A et al. 2005; Wallerstein, N. et al. 2003; Viswanathan, M. et al., 2004) special issues of academic journals, and the recent Institute of Medicine's (IOM; 2002b) call for CBPR to be taught as a core competency to all incoming health professional students. Minkler & Wallerstein, N. (2003: 4) states:

> *"Community-based participatory research (CBPR) equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities.*

Indigenous research methodologies have also contributed to literature to reformulate and reclaim research efforts toward self-determination and cultural restoration. In her book, *Decolonizing Methodologies Research and Indigenous Peoples*, Linda Tuhiwai Smith (1999), a Māori researcher, presented 25 indigenous projects as examples of culturally based methodologies. Integrating these methodologies and culturally supported interventions with empirical supported interventions and methodologies can challenge the existing dominance of a single scientific discourse and work to equalize power relations based on knowledge within CBPR partnerships (Miller, R.L., Shinn, M. 2005).

These frameworks have played an important role as an educational vehicle and/or context for analysis, through supporting processes in reducing disparities in health and improving health services. It provides a template to maintain continual opportunities for self-reflection about ourselves, our institutions, and culture and for dialogue around this self-reflection with other parties who have an invested interest. These practices invoke the challenge to call forth our deepest aspirations for higher education and public health practice, through being of service and working to reduce suffering. These values underline process with communities, in the science and how we present ourselves, and support our goals in doing this work. More pointedly, participatory research has been framed as an orientation to research that focuses on relationships between research partners and goals of societal transformation (Wallerstein, N. et al. 2003), rather than a specific set of research methods or techniques. PAR is not simply a community outreach strategy but represents a systematic effort to incorporate community participation and decision making, theories of etiology and change, and community practices into the research effort.

There are many names action research is known by; collaborative inquiry, participatory research, action learning, and emancipatory research. PAR is learning and applying/doing where an individual or a group of people identify a problem, then proceed in doing something to resolve it, see how successful it was, and if not satisfied, try again. While this is the essence of the approach, there are other key attributes of action research that differentiate it from common problem-solving activities that we all engage in every day. According to Gilmore, T. et al. (1986:160-76) provides a succinct definition;

> *"Action research aims to contribute both to the practical concerns of people in an immediate problematic situation and to further the goals of social science simultaneously. Thus, there is a dual commitment in action research to study a system and concurrently to collaborate with members of the system in changing it in what is together regarded as a desirable direction. Accomplishing this twin goal requires the active collaboration of researcher and client, and thus it stresses the importance of co-learning as a primary aspect of the research process."*

Its unique principles guide the research and has four steps: reflection, planning, action and observation and as noted previously generally starts from an issue or concern and is turned into a common goal. More recently, both globally and in Aotearoa, participatory action research is being used in community projects to ensure that the voices of marginalised populations are included and contribute to local solutions. Over the past few years in Aotearoa there are a number of Māori youth projects that have used KMR and PAR approaches to achieve youth solutions to youth issues. Webster, J. et al (2007: 1) suggest that the PAR approach "attempts to achieve rangatahi desired outcomes by valuing the experiences of the participants and giving rangatahi a sense of ownership over the research."

The intervention is based on two primary assumptions for improving health outcomes and reducing disparities: one, that interventions can be strengthened if they benefit from community insight and incorporate community theories of etiologic and change into the empirical science base; and two, that there is an added value to participation itself for enhancing health (Buchanan, B.R., Miller, F.G., Wallerstein, N.B. 2006). Participation in the community development literature has been well studied as to its purposes, that is, to reduce dependency on health professionals, to ensure cultural and local sensitivity, to facilitate sustainability, to enhance productivity of programs (Jewkes, R., Murcott, A. 1998; Rifkin, S.B., Muller, J., Bichmann, W.1988).

The literature on participation is strongest in the evidence that participation contributes to program improvement through greater efficiency, sustainability, and more equitable distribution of services (Isham, J., Narayan, D., Pritchett, L. 1995; Narayan, D. 1992). There is evidence that empowerment strategies can improve health among different subpopulations in closely constructed, theoretically driven interventions, including patient and health care consumers; and those populations, particularly at risk populations. Furthermore there has been several assessment tools that have been developed in measuring outcomes of participation that has assisted to identify the level of community engagement throughout the research process (Brown, L., Vega, W. 2003; Green, L.W. et al. 2003), and to assist health departments to identify their capacity to engage community partners (Parker, E., Margolis, L.H., Eng, E., Renriquez-Roldan, C. 2003).

PAR can be a powerful tool for change and improvement in health services for indigenous people when utilised within an appropriate framework. Reason, P., Bradbury H. (2001:1) suggests PAR requires;

> *"A participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview which we believe is emerging at this historical moment. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities."*

PAR works in empowering through participatory ways to generate research based solutions to problems that impact on the well-being of people and communities. It focuses on participation and change, using qualitative, quantitative or mixed methods depending on the issues and context, consisting of planning, implementing change and evaluating the results.

It consists also of recognizing that all research is embedded within a system of values and promotes some model of human interaction, commitment of oneself to a form of research which challenges unjust and undemocratic economic, social and political systems and practices. This notion of systems of values is further discussed by Fricke, W. (2002) stating;

> *"Empathy and listening while meeting the other, it is a commitment to basic values like human creativity and democratic participation, it is based on the perception of social reality as a continuing process with individuals being subjects of their history and the social contexts they are dependent on."*

Therefore a key value of action researchers is the abiding respect for people's knowledge and for their ability to understand and address the issues confronting them and their communities. Kerr, S., et. al. (2003) reflects this position when he suggests that task should be to:

> *“Provide people with the support and resources to do things in ways that will fit their own cultural context and their own lifestyles. The people, we knew, not the experts, should be the ones to determine the nature and operation of the things that affected their lives.*

Furthermore, a collaborative approach to research involving all people in the research process, recognising the unique strengths that each brings. Action research begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities. Acton research therefore must be rigorously empirical and reflective, must engage with people as active participants in the research process that results in some practical outcome related to the lives or work of the participants. It enables participants to investigate systematically their problems and issues, support and formulate powerful and sophisticated accounts of their situation and provide plans to deal with the problems at hand.

Action research is not research that one hope’s is followed by an action, it is action which is intentionally researched and modified, and this process leads to the next stage of action which is then examined for further change as part of the research itself. A key part of this process is critical reflection which is a form of analysis that not only explores how and why things happened but identifies the assumptions underpinning that analysis.

The role of the researcher therefore, is not that of an expert who does the research, but that of a resource/support person. He or she becomes a facilitator who acts as a catalyst to assist stakeholders in defining their problems clearly and to support them as they work towards effective solutions to the issues that concern them.

Finally the intricate components of the journey to document using KMR and PAR is partly about the process when one reaches out and engages with participants; what is done with the participants once researchers have engaged with them, and what happens to the participants as a result of the engagement. Therefore a dual paradigm methodology for this research is considered the best pathway not only to investigate process but also to align this understanding with the research questions for this thesis.

Dual Paradigm Approach – Māori and Participatory Action Research

The research methodology applied KMR and PAR approach, Smith, L.T. (2006:7) states:

> *'participatory action research, Kaupapa Māori* research, *oral histories, critical race theory and testimony are just some examples of methodologies that have been created as research tools that work with marginalised communities, that facilitate the expression of marginalised voices and that attempt to represent the experience of marginalisation in genuine and authentic ways'.*

PAR, emphasising empowerment, aligns with the KMR requirement for research to be conducted in Māori ways, dealing with issues important to Māori and likely to be of benefit to us. This congruence allows incorporation of the PAR processes into a KMR framework. PAR shares the principles of emancipation, self-determining communities, effecting social change, acknowledging and transforming participant's expertise into solutions, capacity building and collaboration. PAR has not, however, been constructed from a Māori worldview and therefore is not founded in a Māori-centred position but when applied by Māori using '*tikanga Māori'* (customary practices), knowledge and skills, it has the potential to meet the needs of many Māori research projects including those with whānau.

The parallel between KMR and PAR are notable. PAR grew out of social research methodology, community participation in decision making, and socio-technical discourse (Whyte, E.H. 2007: 7). It involves the active and creative participation of previously marginalised groups in the research process, from the initial design to the final presentation of results. In essence, it forces the open examination of relationships between researchers and those groups under study.

With regards to Māori, it gives way to kaupapa Māori principles in the sense that Bishop argues, is as a local response to Māori concerns and interests, which could only happen in New Zealand. KMR and PAR seek to centre community concerns in research and interrogate systems of power to reposition some control with those directly affected (Cram, F. 2001, Reason, P., Bradbury, H. 2006). KMR utilises Māori frameworks, ecological, holistic and communitarian for understanding the world, human activity and well-being within it (Smith, L.T. 1999, Durie, M. 2000) with important implications for approaches to research. It focuses on Māori advancement, adopting a theoretical position and multi-methods approach born of the need to challenge colonising power, norms and assumptions, so that Māori ways of knowing and operating are central. Māori worldviews have profound effects on how Māori see and utilise methodologies and fundamentally shape their relationships to knowledge and practice.

Moewaka Barnes, H. (2000) emphasises three defining principles of this approach: it is by Māori for Māori. Māori worldviews are the normative frame, and research is for the benefit of Māori. It naturalises Māori epistemologies, methodologies and practices so that Māori are not articulated as the 'other'. PAR works by empowering, participatory ways (Reason, P., Bradbury, H. 2006) to generate research based solutions to problems that impact on the well-being of the people and communities. It focuses on participation and change, using qualitative, quantitative or mixed methods depending on the issues and context, in cycles where each revolution consists of planning action, implementing change and evaluating the results. Knowledge created in the process of solving problems becomes the basis for further actions (Khanlou, N., Peter, E. 2005).

PAR is supported by a growing body of literature showing effectiveness in providing innovative solutions to health issues in a wide variety of settings (Panelli, R., et al. 2006). Both KMR and PAR are context-specific and tailored to purpose and desired outcomes (Moewaka Barnes, H. 2000, Israel, B., et al. 2003). PAR, emphasising empowerment, aligns with the KMR requirement for research to be conducted in Māori ways, dealing with issues important to Māori and likely to be of benefit for them. This congruence allows incorporation of the Action Research processes into a Kaupapa Māori Research framework.

Kerr, S., et at, (2009) research study using KMR methodology was used to improve heart disease services in Aotearoa, New Zealand. It described an innovative use of indigenous action research to tackle a serious and deep-seated source of health inequity. KMR principles guided and resourced the development and implementation of the research action reflection process that contributed to multiple material changes that reduced suffering and stress for Māori with ischaemic heart disease and their whānau in Te Tai Tokerau. In this study there were several key issues raised in the interface of the two worldviews: having lived under an imposed colonial system for 160 years, Māori have developed first-hand experience and a good knowledge of medical systems, including how we are perceived within them. Other research reveals that health professionals do not appear to have a reciprocal understanding of the Māori world. Our approach allowed Māori experiences to be articulated and developed as a resource to facilitate change.

The most significant outcome from the sharing of narrated experience is that health systems have been modified, primarily by health professionals who wield the most power to effect systemic change, allowing Māori participants to work for change without having to take all the responsibility for creating it. The research findings indicate the need to investigate the impact of epistemological difference between health practitioners and their patients across the sector and action research is demonstrated to be a potentially useful tool for moving past investigation towards generating solutions. At the local level, the research indicates that more work is needed to improve cultural competency amongst professionals (Medical Council of

New Zealand 2006) and to develop health services that are able to engage more appropriately with Māori in order to improve delivery and outcomes. This research has contributed to smoother pathways to care, better access to treatment and more culturally appropriate on going care for Māori with ischaemic heart disease in Te Tai Tokerau. These are good outcomes for a small-scale, short-term action research project.

KMR represents a significant tool in opportunities to work with Māori communities toward the goals of health equity supported by recent work on the social determinants of health promoted by the World Health Organization (Commission Social Determinants of Health, 2007). When considering developing research research projects involving indigenous people those communities should be given the option of the PAR. The Canadian 2007 Guidelines for Health Research Involving Aboriginal Peoples state that this approach has emerged as a deliberate form of resistance to traditional research practices that were perceived as a colonizing tool by research participants. The strength of engaging in PAR with indigenous communities has also been highlighted by a number of Māori scholars (Bishop, R. 2005; Smith, L.T. 1999, 2005). There are like any other methods a number of challenges and tensions PAR faces. McHugh, T.-L.F., Kowalski, K. (2009) research with young aboriginal women indicated several issues when they used PAR: defining the community, negotiating informed consent, relationships with researcher and community, and participant collaboration.

PAR is proving to be very effective in research with Māori and this is evidenced by the increased use of this approach with Māori projects over the past few years. It has potential for use within Māori research projects when a meaningful collaborative process. The principles align with many of the kaupapa Māori principles of self determination, and emancipation. PAR is able to respond to the diversity of Māori and has the ability to progress Māori development.

The Study Protocol

It was proposed 100 Māori (aged 20+) living in the region of South Auckland communities who had been diagnosed or not diagnosed with gout were the key participates in the research. The participants were asked to participate in a one to one interview with the researcher to share their individual stories on living with gout. Complete a pre and post *whakamā* (inner consciousness, facial/body expression) questionnaire to assist in unearthing the myths about gout, to gauge a deeper understanding of the breadth and depth of the states that suppressed participants accessing health services.

They were also asked to join and attend with other participants four *Wānanga-a-hui* (focus group) on a marae. The four *Wānanga-a-hui* focused on the conceptualisation, the development, and the implementation and evaluation process of the *whakapapa* (genealogy) model about gout. The research was conducted in three Māori health providers, Papakura marae, Turuki Health Care and Raukura Hauora O Tainui who offer primary and secondary care services in the South Auckland communities. Most significantly the ethos of these Māori health providers is their Māori cultural beliefs and values that permeate all aspects of the organisation and shapes and influences the planning, development and implementation of all health care programmes delivered. The importance of conducting this research within these three Māori health providers is the alignment of the research design and the ethos of these organisations.

An information sheet outlined the research were placed in three Māori Health Providers in South Auckland; Papakura marae Health Services, Turuki Health Services, and Raukura Hauora O Tainui, with contact details of the researcher. Māori *whānau/family* (participants) were provided with an overview of the purpose of the research, consent form/s outlining an agreement to take part in the research, the role of Papakura marae, Turuki Health Services, and Raukura Hauora O Tainui. The researcher's role and the selection process of participants and what will happen to the data after the completion process.

Tikanga (protocols) formed the basis of ethical engagement with all parities; *Tikanga* (protocols) is viewed in terms of Māori custom lore that is also referred to as *tikanga Māori* (Māori protocols). *Tikanga* referred to values, beliefs, standards, principles and norms agreed by all participants and defined by them. It provided correct practice of the researchers engagement with Māori *whānau*/*family* (participants) and the receiving and holding of information.

Ethcial considerations for Māori whānau (participants)

Tikanga (protocols) in the context of this research ensured correct engagement between the researcher and Māori whānau (participants) reflecting the true spirit of partnership, protection and participation. Participants were fully informed of the process undertaken in this research and how the information shared during this research will be treated.

The above process using *Tikanga* (protocols) was applied when seeking approval from Papakura marae, Turuki Health Care and Raukura Hauora O Tainui Boards of Trustees to undertake this research within these organisations and Counties Manukau District Health Board Māori Research Council and Te Whare Wānanga O Awanuiarangi Ethics Committee. The approval from these Health Providers is required as participants in this research are potential *whānau* (clients) accessing Papakura marae, Turuki Health Care and Raukura Hauora O Tainui primary and secondary Services. This process required several *hui* (meeting) with key people in these organisations and an overview of the research was presented to staff prior to the research being undertaken.

Conflict Resolution Approach

Tikanga (protocols) will form the basis of conflict resolution by:

Step One

Māori *whānau*/*family* (participants) who have concerns in the process of this research, in the first instance if possible, a *Hui* (formal meeting) will be organised with the researcher using a *whakanoa* (clearing the pathway) process for consideration:

- *Karakia/waiata* (prayer/hymn)
- *Mihi* (formal speech of greeting)
- Participants and their *whānau*/*family* concerns presented
- Researcher response
- Resolution sought
- *Hongi* (formal engagement, pressing of noses)
- *Kapu ti* (light refreshments)

If this process is unable to reach a resolution or Māori whānau (participants) do not wish to engage with the researcher step two will apply;

Step Two: Kaumatua Taumata (Council of Māori elders)

- *Kaumatua Taumata* (Council of Māori elders) to meet with Māori whānau (participants) using a whakanoa process to reach a resolution.
- *Kaumatua Taumata* (Council of Māori elders) and the researcher will meet to discuss the outcome of the hui with recommendations
- Final hui will include all parties – *kaumatua Taumata* (Council of Māori elders), researcher and Māori whānau (participants), using a *whakanoa* (clearing the pathway) process, in the way forward
- Māori whānau (participants) will receive in writing from the *Kaumatua Taumata* (Council of Māori elders) the outcome of *hui* (formal meeting)

Risk Management:

The possible challenges for this research will be firstly the recruitment of Māori whānau (participants). The selection process is to place a flyer/poster outlining the research in Papakura Marae Health Services, Turuki Health Care and Raukura Hauora O Tainui primary and secondary services. This process aligns to *Tikanga* (protocols) in the sense Māori whānau (participants) will choose to participate and is less invasive for them than for the researcher to access the databases of these Health Providers. The other possible issues are: changes in participant's lives and as a result may wish to withdraw from the research, rescheduling timeframes for one to one interviews and Wānanga and work commitments.

Contingency Plan

The contingency plan consisted of; the researcher attending Poukai ki Tamaki me Waikato if unable to recruit through the Health Providers, recruit 150 Māori whānau (participants) to accommodate whānau (clients) who wish to withdraw, benchmark 100, allow an extra three months flexibility for timeframes and scheduling, researcher to negotiate clear timeframes with scheduling of research for Management approval at current employment, Counties Manukau District Health Board, Te Kaahui Ora Māori Health Unit.

Data Collection

Māori *whānau*/family will be asked to participate in one individual face to face interview to share their experiences of living with gout. To complete a pre and post *whakamā* (inner consciousness, facial/body expression) questionnaire to assist in unearthing the myths about gout, to gauge a deeper understanding of the breadth and depth of the states that suppressed participants accessing health services. Māori *whānau*/family will also be asked to participate in two *wānanga* where the *whakapapa* (genealogy) of gout will be developed. Māori *whānau*/family will be offered 6 months follow up support thereafter; the support framework will be based on the cultural model, the interventions and contra indicators identified in the *wānanga*. All participants will give written consent prior to participating in the research and fully consent to; sharing their knowledge, giving permission to use this information in the research, to request to read the information prior to the thesis been submitted. The information will be held the researcher's current employment in a locked cabinet that only the researcher has access to. In accordance with the Privacy Act 1993, the information will be held for five years from the time of collection and will be shredded by the researcher.

Māori Gout Sufferers and Research

Although Māori experience has shown that research at best is often viewed with contempt and at the least with suspicion and in particular health. Kaupapa Māori is viewed as the most appropriate process to undertake with Māori participants. It is grounded in cultural values, beliefs and processes providing a guide in which to build on the resilience and strengths of Māori communities, their environments, and recognise the opportunity for Māori to take a lead role in the development of initiatives that support them through this important part of their pursuit to their wellness.

Tikanga (Protocols)

The w*hakapapa* (genealogy) framework provided the appropriate engagement and practice of Māori beliefs, values and collective practices. Te Puni Kokiri (1992) defines *tikanga* (protocols) as ethics:

> *"Ethics is about values, and ethical behaviour reflects values held by people at large. For Māori, ethics is about 'tikanga' – for tikanga reflects our values, our beliefs and the way we view the world."*

Tikanga (protocols) guided the process used throughout the research while working with Māori and included protocols as a guide to safe and inclusive processes and behaviours that encouraged and developed cultural customs. This included the use of consent forms, disclosure protocols and other such ethical safeguards. *Tikanga* (protocols) *was* essential for safe implementation of kaupapa Māori research.

Tikanga (protocols) may include measurements in dealing with actions that may cause serious imbalance within the community, and it serves as a way of doing things with *consideration of being morally appropriate and courteous.* (William, J.1988:8*). Tikanga (protocols)* embodies beliefs and practices associated with procedures to be followed in conducting the affairs of a group or individual. Furthermore, Meads, H. (2000) suggests procedures are established to be ritually correct, are validated by generations and are always subject to what a group or an individual is able to do. *Tikanga* (protocols) can also be referred to as values, beliefs, standards, principles or norms, which Māori communities subscribe to as appropriate for that particular community.

It can be a tool of thought and understanding, suggesting packages of ideas, which help to organise behaviour and provide some predictability in how activities are carried out. It can provide templates and frameworks that assist in guiding actions and help individuals or groups. Mead (2000) suggests it can steer people through huge gatherings of people and some tense moments in individuals' ceremonial lives. Manuhuia, A. (2001) suggests *tikanga* (protocols) indicates the obligation to do things in the right way, doing the right thing for no other reason because it is the right thing to do. *Tikanga* (protocols) may draw from different seeds; it has many shades and many applications. It comprises a spectrum of values at one end and rules at the other, but with values informing the whole range. The real challenge in *tikanga* (protocols) Williams, J. (1998:8) states is to understand the values because it is these values, which provide the primary guide to behaviour.

Summary

This chapter has introduced the two methodological approaches undertaken in this thesis: Kaupapa Māori and Participatory Action Research and summarised the features of each. I have positioned that both approaches can interact in the same space together reflecting on previous research studies who have applied a dual paradigm approach. A poet by the name of Robert Frost (1963) sums up perfectly the rationale of selecting a dual paradigm approach for this research, he states, "*two roads diverged in a wood, and I took the one less travelled by, and that has made all the difference."* Although dual approaches in research have grown momentum over the past decade, it is still a road that has been the one less travelled. The next chapter examines a dual paradigm approach using Kaupapa Māori (Māori worldview)/a Māori human growth model and a clinical process about gout framed by whakapapa (genealogy) epistemology.

An examination of a dual paradigm approach using *kaupapa Māori* (Māori worldview), clinical process about gout, and framed by whakapapa (genealogy) epistemology forms the discussion in chapter five. The first section will explore *whakapapa* (genealogy) framework using *Te Kore* (the abyss), *Te Po* (voids of darkness) and *Te Ao Marama* (world of light) This framework will assist in describing behaviours and characteristics of individuals experiencing gout. Buck, T.H. (1949) Māori human development model *Te Pu* (root cause), *Te Weu* (rootlets), *Te More* (taproot), *Te Aka* (the vine) and *Te Tipuranga* (growth) will track stages of growth and development within the *whakapapa* (genealogy) paradigm based on the notion of something evolving from nothing. The second section will explore the clinical process of gout suffers from the perspective of a medical model in understanding the chemical imbalances that create the pathway of a gout attack, the compounds that are found within this process that signpost this pathway and to connect uric acid and crystallisation in gout. The clinical pathway on gout depicts a *whakapapa* (genealogy) order and the inter-relationships this pathway undertakes. The Final section investigates systems thinking within the two worlds: *whakapapa* (genealogy) paradigm, Māori human growth and development, clinical process for gout, demonstrating the intertwining of the two schools of thought.

Chapter Five

The Dual Paradigm: Kaupapa Māori/Clinical Process about gout

A Māori worldview provides a wealth of concepts, principles and values that are used and applied through time. It provides generations to engage in cultural responsibilities and obligations. Furthermore, Pohatu, T.W. (2003:3) claims Māori worldview provides,

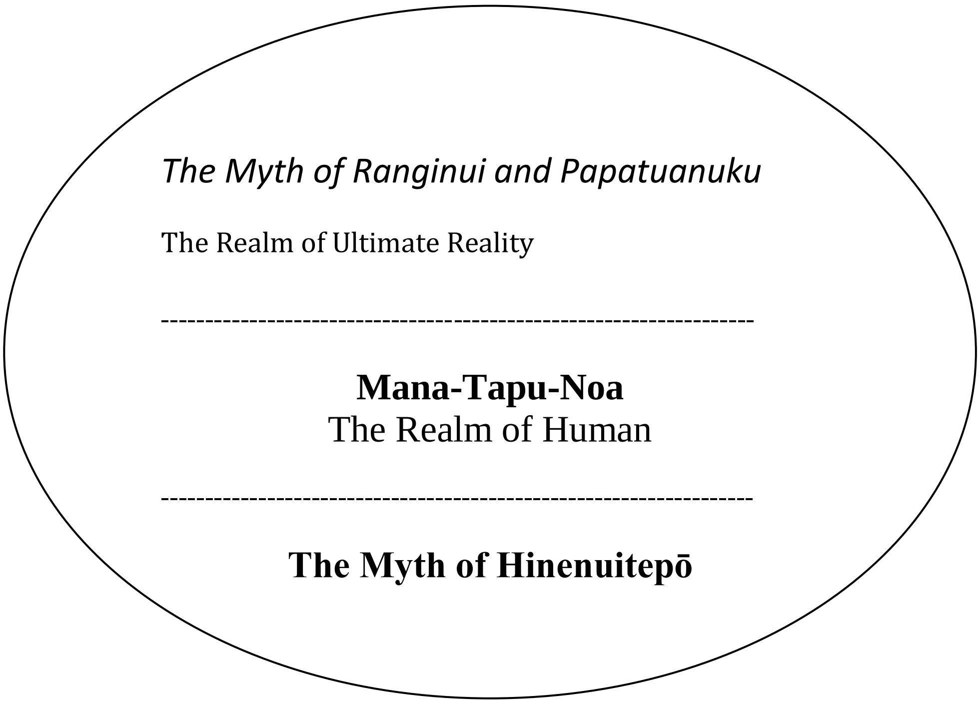
> *'Generations are able to add their layers of experiences and analysis, informed by reality of each new time." It is informed, developed, nurtured and defined by Māori. It is the source of Māori knowledge that provides a pathway to Māori wellness to confirm Māori are part of nature. Māori believe the spiritual realm interacts with the physical world and vice versa.'*

The Ngai Tahu Seas Fisheries Report (1992:5) reinforces this position.

> *'Māori myths and legends support a holistic view not only of creation but also of time and of peoples. To understand this concept, it is important to look at how Māori see the world that they live in.'*

Irwin, K. (in Marsden, M. 2003), describes the Māori worldview as a three-tiered structure consisting of the following dimensions depicted (Diagram 1). The first tier represents the 'spiritual realm' that encompasses all *kaawai tīpuna* (direct ancestor) that are found within Māori tradition. The second tier represents the present day, all people who are living. The third tier is a representation of *tīpuna* (ancestor) who are now under the care of *Hinenuitepo* (Goddess of Death). The dotted line (diagram 1) represents the reality that they are not closed off from each other because Māori who are living believe that their *kawai tīpuna* (revered ancestor) and their *tīpuna* (ancestor) exist alongside them. The interaction between the spiritual realm and physical realm is evident in cultural practices. Those who have passed on live through the living generation and in turn will live through those that follow. This concept of regeneration is contained in the concept of *whakapapa* (genealogy).

The Māori Worldview



The Myth of Ranginui and Papatuanuku

The Realm of Ultimate Reality

Mana-Tapu-Noa
The Realm of Human

The Myth of Hinenuitepō

Korero tawhito (historical messages, discussions, talk) record the deeds of *kaawai tīpuna* the *mana* and the history. *Korero tawhito* lay down the ethical principles of the *tīpuna.* Patterson, J. (1992:7) describes the attitude of Māori to the past.

> *'To a Pakeha the past generally lies behind, one's aims, aspirations and goals relate to the future, which lies ahead. For Māori the opposite holds. The past is ahead not behind, and it is there that one finds one's models, one's aims, aspirations and goals.'*

A spiritual conception of the universe served in developing the values and sanctions of Māori society. The creative activities of the *kaawai tīpuna* and the activities of real people have underlying themes, which influenced the way Māori society operated and their behaviour patterns. Metge, J. (1967:8) supports this view by asserting, "*Māori mythology and an elaborate system of ritual governed all human activities and relationships*.

Whakapapa Paradigm

Whakapapa is informed, developed, nurtured and defined by Māori. It is the source of Māori knowledge that provides a pathway to Māori wellness confirming Māori are part of and have a relationship with their natural environment. *Whakapapa* (genealogy) paradigm provides key concepts that strongly influence the attitudes and behaviour of Māori people today. The philosophical ideals underpin the way Māori deal with the world and influences many ideals and actions.

It is embedded in Māori cosmogony in the epochs that begins with *Io* (the supreme deity) who brought into being *Te Kore* (the abyss), *Te Po* (darkness) and *Te Ao Marama* (the light). The *whakapapa* (genealogy) paradigm provided a vehicle to generate and transmit Māori worldviews and knowledge giving wider and deeper meanings to the *whakapapa* (genealogy) paradigm purpose, function and performance that will contribute to Māori advancement and increase Māori control over their own future. Ratima, M. (2003) asserts, *"Māori recognise that reality is culturally bound and that what is real is dependent upon the window of cultural values through which one perceives the world." Whakapapa* distinguishes Māori from any other race, nationally or community. It is a proclamation of individuals' and communities origins. It provides for the potential for all iwi and hapu members to know where they are positioned in relationship to others, Hemara, W. (2000:33) states:

> *"Māori individuals that hold positions on a whakapapa continuum, connecting to everyone else, these links are part of an ever-widening cycle of relationships where information is continually being transmitted and received."*

Te Kore (Abyss)

An exegesis of the cosmogony gives insights into the main philosophical influences of in the *whakapapa* (genealogy) paradigm. *Te Kore* (abyss) signified space and depicts the Māori phenomenology world of existence that contained in its vastness the seeds of the universe, the celestial realm, the domain of the gods, and the world of light that is the dwelling place of humans. It is the means by which there is interpenetration of the realms of humans, into the realms of the dead and the realms of the gods.

Te Kore (the void of nothingness that exists without shape or form)
Te Kore (abyss) the timeless, perfect and uncreated.
Te Kore te whiwhia (the void in which nothing could be obtained)
Te Kore te rawea (the void in which nothing could be felt),
Te Kore I ai (the void with nothing in union)
Te Kore te wiwia (the space without boundaries).

In the beginning *Io* (God) existed alone in the realm of *Te Kore* (abyss), nothing existed before *Io (God)*, he was the truly supreme god and dwelt tranquilly in the void of *Te Kore* (abyss). His essence flowed forth to fertilise *Te Kore* (abyss). He spoke and commanded the night, the heavens, the light, the earth and water. Thus were the essential foundations of the universe laid. According to Marsden, M. (1985) only the seed of potential being was established and there was no form or substance for this seed of creation gestated in *Te Kore* (abyss). Then *Io* (God) activated himself and recited the names of the different foundations of things: of the night and light, of the earth and sky and waters and things took form.

Te Kore (the abyss) signified space and depicted the Māori phenomenology world of existence that contained in its vastness the seeds of the universe, the celestial realm, the domain of the gods, and the world of light that is the dwelling place of humans. It is the means by which there is interpenetration of the realms of humans, into the realms of the dead and the realms of the gods. Walker, R. (1990) view of *Te Kore* refers to voids that signify the aeons of time during which the primeval matter of the universe came together and generated *Papatuanuku* (earth mother) and *Ranginui* (sky father). *Te Kore* (abyss) signifies the realm between non-being and being, that is, the realm of potential being. It is the realm of primal and elemental energy or latent being. According to Marsden, M. (1985) it is here that the seed-stuff of the universe and all created things gestate, it is the womb from which all things proceed.

A contemporary perspective of *Te Kore* (the abyss) is used as an opportunity to identify stages of underdeveloped growth due to significant events in one's life and in this instance gout. A person may be seen to be in *Te Kore* if those events have led to the individual's life becoming monotonous, where aspirations do not take form. The person may be despondent and feeling alone, the only focus is the self. However, the person can begin to disperse *Te Kore* by beginning to make positive decisions and seeking support but this is still a fragile part of existence. *Te Kore te whiwhia* (the void in which nothing could be obtained) is described as time that a person is reflecting, pondering, or mediating over the unresolved events or issues they are facing. This may look as if nothing is happening, but can be a time of the greatest growth where the journey ahead is planned and understood. This can be a time of understanding the lessons of life.

Te Kore te rawea (the void in which nothing could be felt) is a place where feeling is restricted to the *hinengaro* (mind) and the *wairua* (spirit): the *ihi, wehi and mana* (energy, vitality and integrity). In this way it has a relationship with *Te Kore Te Whiwhia* (the void in which nothing could be obtained), with the emphasis on 'rediscovering'. So positive decisions are being built upon, it is viewed as *'oho ake'* (awakening) of the inner self.

Te Kore i ai (the void with nothing in union) from a contemporary view *Te Kore i ai* (the void with nothing in union) is defined as a state of confusion; misperception that can have devastating effects. This is a reminder that a past situation, that has not been adequately dealt with requires attention before progress can be made. It is a reminder to take the opportunity to build boundaries and structures at this time. *Te Kore te wiwia* (the space without boundaries) is viewed as both esoteric (common knowledge), and exoteric (*tohunga* or expert knowledge), referring to infinite distances. Individuals may realise their relationship with ancestors and begin to value their place within their *whakapapa* (genealogy), and within their *whānau*/*family*. It gives a better understanding of oneself as part of the vastness of the universe, within a boundless kinship design. There is closeness to those of near *whānau*/*family* as well as closeness to those long gone. This is the *taonga* (gift/treasure) of *whānaungatanga* or kinship relationships and is related to the tasks within *Te Kore te rawea* (the void in which nothing could be felt).

Te Po (voids of darkness)

Te Po (darkness) is the second state of existence. The *whakapapa* of Te Po:

Te Po (darkness)
Te Po nui (the great night)
Te Po roa (the long night)
Te Po uriuri (the deep dark evolvement)
Te Po Kerekere (the intense night)
Te Po Tangotango (the intensely dark night)
Te Po Whawha (the night of feelings)
Te Po Namunamu-ki-Taiao (the night of seeking the passage).

As in *Te Kore* (abyss), these periods of *Te Po* (darkness) correspond to aeons of time when the earth came into being. Both *Te Kore* (abyss) and *Te Po* (darkness) signified the emptiness and darkness of the mind, because there was no light and no knowledge. The reason for this state of affairs according to Walker, R. (1990) was that during *Te Kore* (abyss) the primeval pairing of *Ranginui and Papatuanuku* (Sky-Father and Earth Mother) prevented light from entering the world. The aeons of *Te Po* (darkness) mentions several phases that are closely linked with the embryo earth, with the waxing moon, and with death and the after world of spirits. The complexities of *Te Po* (darkness) are endless and these periods of darkness are in a sense pre-creation and phases of creation. Best, E. (1995) refers to *Te Po* (darkness) as the period of time prior to the existence of the universe. It is the period of labour of the Earth Mother, the period of time after death and the underworld. *Te Po* (darkness) is the intangible, unknown and unseen that denote phases of darkness. *Te Po* (darkness) is the realm of becoming and *Te Ao Marama* (the world of light) is the realm of being. Buck, T.H. (1950) adds further layers in Te Po stating:

> *'The development of Ranginui and Papatuanuku occurred during Te Po and from this relationship derived the male and female principles. Ranginui and Papatuanuku joined and they lay in an embrace so the world was still shrouded in a darkness that inhibited growth, progress and an increase in knowledge.'*

During this time they produced children of which six are well known because of the Grey, G. (1995) collection of tribal myths: *Tanenuiarangi* (ancestor of the forest), *Tawhirimatea* (ancestor of the winds), *Tumatauenga* (ancestor of war), *Tangaroa* (Ancestor of the sea), *Rongomatan*e (ancestor of peace, kumara, cultivated plants), and *Haumiatiketike* (ancestor of fern root, uncultivated foods). The myths and legends for *Tumatauenga* (ancestor of war) asserted to kill their parents but relented when *Tane* asserted they separate their parents to promote growth and life. All but one of the sons, *Tawhirimatea* (ancestor of winds) participated in the incident. However, *Tanenuiarangi* (ancestor of the forest) was held responsible for the separation of his parents. *Ranginui* (sky father) was thrust high above *Papatuanuku* (earth mother) so that there would be room to move around and light could enter the world. These stories contain within them concepts that are intrinsic to Māori principles and values. *Tanenuiarangi* symbolises 'best practice leadership' because he effected change that benefited all of mankind. These are notions that are intrinsic to the development of a whakapapa model about gout.

Te Po nui (the great night) is reflected as the immeasurable darkness, for the individual, this is a time when misery is so deep it is like being in a bottomless pit – a black hole wherein one could easily disappear forever. In this state, communicating clearly can be exceedingly difficult if not impossible and sufferers have described it as a time when they have been choked up with too much emotion and frustration. *Te Po roa* (the long night) signifies the time of continuous darkness. For the person this is a time of recognition and a sudden desire for an end to the darkness. There may be a developing consciousness of his/her situation and circumstances and a desire for progress. *Te Po uriuri* (the deep dark evolvement) is a time of evolvements in the deep darkness. Here there is progress towards action; it is described as a heart-breaking stage, where decisions may involve unselfishness in the choices made. *Te Po Kerekere (*the intense night) the time of decision-making has arrived; thought is shifted from analysis to action where the past is compared with possible futures and is dependent on the decisions made; decisions can be proposed but not carried through due to lack of commitment and limited knowledge. *Te Po Tangotango* (the intensely dark night) seems the darkest time of one's life where decisions made must be followed by action, the experience is intensified, where a paradigm shift occurs which impels action either forward or backwards. *Te Po Whawha* (the night of feelings) is where the physical senses are inhibited. It is important to momentarily restore the senses in order for the person to find their way through the darkness and also to help with balance as this stage feels like walking on a tightrope.

Te Po Namunamu-ki-Taiao (the night of seeking the passage) the task here is seeking, it is a realisation that it is time to move on, finding the passage back to reality is an exhausting process where the direction is neither forward nor back and is by no means resolved. Positive consequences require assistance from others, so that the processes of self-evaluation may flow unreservedly, negative consequences result from an unwillingness to move onwards. The way to change can become clearer or clouded, depending on the individual's capacity and willingness to make constructive decisions. *Te Po Tahuri atu* (the night of restless turning) is viewed as a spiritual restlessness, the process of restoration and renewal depends on how willing one is to let go of negative attitudes and behaviours. Forgiveness of self and others is necessary at this stage, it is often described as a *Wānanga stage*: to worry the worry, to pursue it in order to reach resolution. It is the moment of ascension from darkness into light, one that is fundamental to the health and well-being of every individual, even if this process is for a short period of time. It is the gasp or sudden intake of breath referred to as '*Tihei mauri ora'* (breath of life).

Te Ao Marama (world of light)

The epoch of *Te Ao Marama* (the World of Light) emerged from the separation of *Ranginui and Papatuanuku* (Sky Father and Earth Mother). This was the time of the gods *(atua*) – who are the ancestors of all Māori. *Tawhirimatea* (*atua* of the winds) attacked his brothers with winds and mighty storms, uprooting the children of *Tane* (*atua* of the forest) and attacked *Tangaroa* (*atua* of the sea) who fled from sea to sea. *Rongomatane* (*atua* of peace/cultivated food) and *Haumiatiketike* (*atua* of the uncultivated plants) were hidden within the bosom of *Papatuanuku* (Earth Mother) from the forces of *Tawhirimatea* (*atua* of the winds). *Tumatauenga (atua* of war*)* was the only brother who withstood the attacks from *Tawhirimatea (atua* of the winds). He considered his brothers to be weak during the attacks so he turned against them by using their children for food and everyday materials. This in pre-Christian times provided the precedence in Māori law for cannibalism.

Tane (god of the forest) was responsible for the creation of humans; he moulded the female body out of the sacred clay from *Papatuanuku* (Earth Mother) and breathed life into the nostrils of the figure. The first female was created and given the name *Hineahuone*, the first *ira tangata* or the human element, which became *Hinenuitepo* (the goddess of death). The union of *Hineahuone* (first human female) and Tane (god of the forest) resulted in the birth of *Hinetitama* (daughter of Hineahuone and Tane). In order for the species to be continued, *Tane* took *Hinetitama* as his wife and produced a daughter. However there are some tribal interpretations of this tradition that view this myth as a prohibition against incest. This is evidenced by the fact that *Hinetitama* on learning the truth about her father/husband fled to the underworld and became the great death *atua* (goddess) Hinenuitepo.

Where *whakapapa* (genealogy) begins so too does the growth of the individual or group. Each component is part of the collective, as generations to come will at some point receive the knowledge gathered by that individual or group which adds to the growth of that line. This may cause a divergence in the growth pattern or create an enlargement or a decreased capacity of flow. Māori society today has many examples of this phenomenon and certainly adds flavour to the development of the individual or group. Another viewpoint, whether in a Māori or non-Māori context, it is clear that what people choose to do with the information or knowledge gained from this process can be used for the betterment of the relationships either from an individual or collective basis.

Whakapapa (genealogy) therefore has the ability to activate, create and bring kaupapa (topic/issues) into being that provides foundations for life experiences to take shape, (Edwards, S 2009:44), creating a framework to articulate and draw from a knowledge system of knowing. These systems are inter-related consisting of ira atua, ira tangata and is a way of explaining te Ao Māori respective relationships of entities in the universe. Whakapapa according to Edwards:[11]

> *"has the ability to ground oneself in something, is the foundation of a Māori worldview, the importance of connections and relationships with entities, its maintenance, enhancement and advancement of these during relationships for wellbeing."*

Māori Human Development Framework

The Māori human development framework tracks stages of growth and development within the *whakapapa* (genealogy) paradigm. Buck's (1949) paradigm of human development framed by *Te Pu* (root cause), *Te Weu* (rootlets), *Te More* (taproot), *Te Aka* (the vine) and *Te Tipuranga* (growth) *is* based on the notion of something evolving from nothing; this idea is supported by Taylor, R. (1855:20):

> '*The traditions of creation go back far beyond the gods themselves. That begun with nothing, then produced something that brought something more, and generated a power of increasing. Spirit, being more subtle than water, arose before it, and thought, supposed to be more so than spirit, the commencement dates with its birth.'*

Te Pu (root cause)

The model begins with *Te Pu* the root cause, the nutrient that causes growth. It is symbolically the lifeline of what can be and what will be and is also a greater state of consciousness. *Te Pu* (root cause) can be seen as the basis of cognitive and instinctive learning and can also be the stage where individuals comprehend that their inappropriate behaviour has a root cause. This is a stage where adjustments in personal behaviour and lifestyle can be considered as necessary for recovery. Understanding the process of

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[11] Ibid: 29

adjustments or behaviour is contingent on redressing negative influences that has been learnt from past experience.

Te Weu (rootlets)

Te Weu is the rootlets or the offshoots from *Te Pu* (root cause) that come off the main root. These symbolises side issues that are related and intertwined to the root cause of behavioural influences. They are the annoyances that generally hinder or slow the process of change and constructive growth. Inevitably the rootlets or side issues become enmeshed with the main issues, and consequently the real causes of behavioural problems are not identified at an earlier stage compromising the journey and or the healing process. *Te Weu* (rootlets) can also assist in differentiating between right and wrong in terms of ethical, moral, emotional, physical, spiritual and psychological rules that maybe observed. The importance of *Te Weu* (rootlets) is to address the rootlets that are seen as side issues or the root cause of behavioural influences, it requires individuals to utilise their learnt skills in overcoming the stage of *Te Weu* (rootlets).

Te More (taproot)

Te More is the taproot or the main arterial root that causes growth and is also the root that can cause a diversion in growth. It can be viewed as any desire to change the direction of growth, requiring manipulation at the beginning of a life cycle. With nurturing and care one is able to add to the quality of life. From a cultural perspective, nurturing should be both positive and negative; these are values that add to a better quality of life. The positives are designed to cause growth and set aims and goals for the future, while the negatives are designed to establish parameters. Therefore, *Te Pu and Te Weu* (root cause and rootlets) is the vitality seen as the continued thread that connects to the development of growth within *Te More* (taproot).

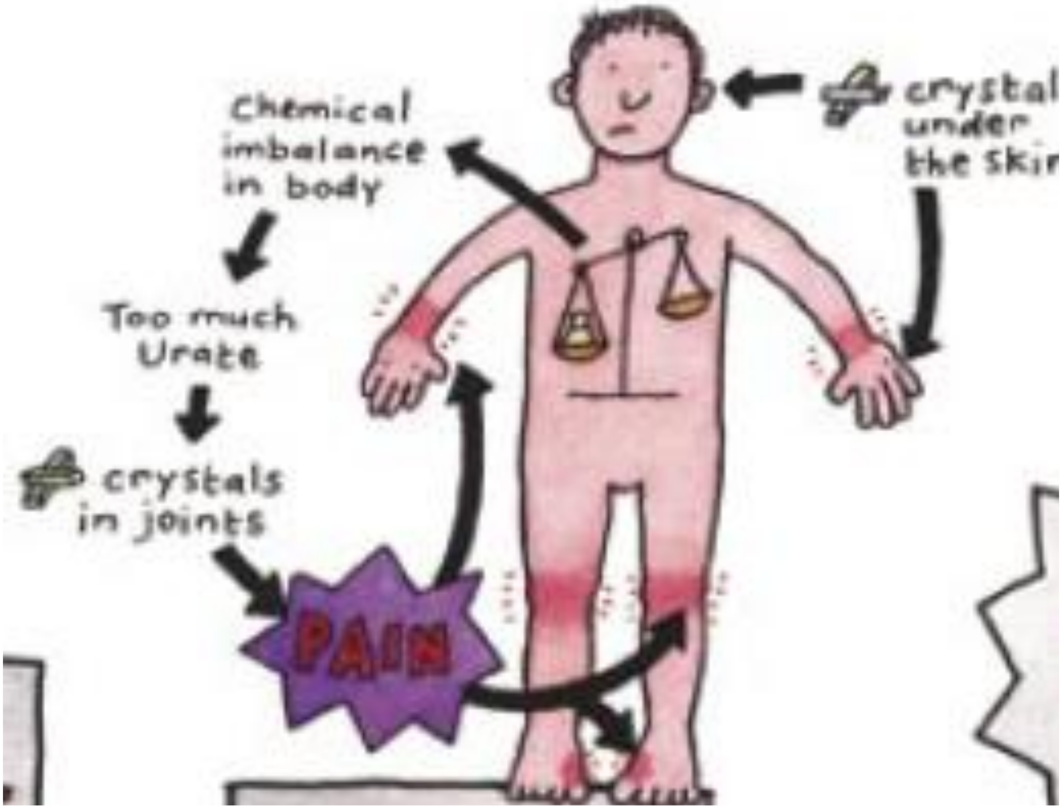
Te Aka (the vine)

Te Aka the vine represents an internal process that is associated with living or the state of being alive. The care and protection given to the taproot and rootlets determines the quality of the vine. The vine as the physical evidence of ancestry is symbolised by the roots and thereby affirms one’s identity. Through the course of this evolvement we are taught fundamental principles that give enhancement to our character, cultural identity and later, it is the individual’s responsibility to take ownership of their identity. However, if the taproot of *Te More* and the rootlets of *Te Weu* do not receive the nutrients provided from *Te Pu*, growth is stunted. The process of growth is activated it can give rise to the individual’s character, responsibility to take ownership of these, and in turn bring about a state of liveliness. This is *Te Aka*; the vine is associated to living and is seen as a process in forming growth.

Te Tipuranga (growth)

Te Tipuranga symbolises growth and it is the time where learning and survival is dependent on the environmental elements to provide and produce nutrients for long-term survival, it is access to the elements of nature, which provides the basis for further development. In human development positive growth depends on the learned beliefs and values which are culturally defined and these elements shape the moral values of the individual. For Māori these values recognise a *wairua* (spirituality) base, Williams, J. (1998) proposes that *whakawhānaungatanga* (culturally defined relationships) shapes ethical behaviour and that these relationships are between people; between people and the physical world; between people and the *atua* (spiritual entities). This perception is similar to the *whakapapa* (genealogy) model which enables a person to trace their descent and this identity binds the Māori world together. *Whakapapa* (genealogy) identifies the nature of relationships with all things emphasising the responsibility owed by individuals to the collective. It provides the individual identity through the individual's relationships with others. *Whakapapa (*through the gods and in particular *Tanemahuta)* is the relationship between people and the environment. This sacred relationship governs the laws, which prohibit Māori from exploiting the natural world for individual profit.

Clinical Process about Gout[12]



The Chemical Imbalance in the body

The diet you follow is one of the biggest causes of gout, it occurs because of your diet making a chemical imbalance in the body that is unable to eliminate uric acid. Uric acid forms when your body breaks down foods containing a substance called purine. Purines are natural substances found in all of the body's cells, and mostly in all foods. Purines provide part of the chemical structure of our genes and the genes of plants and animals. The high-purine foods are also high-protein foods, and they include organ meats such as kidney, fish; mackerel, herring, sardines and mussels, and also yeast. The table below lists some foods that contain higher-than-usual amounts of purines, and high-moderate levels of purine.

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[12] The Arthritis Research Campaign, (2002). A Mind map on Gout.

Foods with very high purine levels(up to 1,000 mg per 3.5 ounce serving):	Anchovies, Brains, Gravies, Kidneys,Liver, Sardines, Sweetbreads
Foods with high and moderately high purine levels(5-100 mg per 3.5 ounch serving):	Asparagus, Bacon, Beef, Bluefish, Bouillon, Calf tongue, Carp, Cauliflower, Chicken, Chicken soup, Codfish, Crab, Duck, Goose, Halibut, Ham, Kidney beans, Lamb, Lentils, Lima beans, Lobster, Mushrooms, Mutton, Navy beans, Oatmeal, Oysters, Peas, Perch, Pork, Rabbit, Salmon, Sheep, Shellfish, Snapper, Spinach, Tripe, Trout, Tuna, Turkey, Veal, Venison

The above is a guideline if you are at risk of gout, or at risk of any other health problems related to purine metabolism. If you have been asked to follow a strict, low-purine diet because of gouty arthritis, you'll want to follow your practitioner's recommendations, and are likely to be asked to limit your consumption of animal foods, fish, and lentils, (Choi, H.K., et al. 2004).

Uric Acid

In the clinical process of gout, uric acid plays a major role in the course of a gout attack. Uric acid is a heterocyclic compound that has atoms of at least two different elements as members and in this case: *carbon* - present in all life forms and in the human body, *nitrogen* - occurs in all living organisms, the human body contains only three percent (3%) by weight of nitrogen, *oxygen* - comprises most of the mass of living organisms and two-thirds of the human body mass, living organisms contain oxygen in protein, carbohydrates and fat, and *hydrogen* - which is rare on earth is a colourless, odourless, tasteless, non-toxic, non-metallic and is present in the water molecule and in organic compounds. . These are members of uric acid; they form ions and salts known as urates and acid urates such as ammonium acid urate. Uric acid is a product of the metabolic breakdown of purine nucleotides. For example high blood concentrates of uric acid can lead to a type of arthritis known as gout. The chemical is associated with other medical conditions such as diabetes and the formation of ammonium acid urate kidney stones.

It's normal and healthy for uric acid to be formed in the body from breakdown of purines. In our blood, for example, uric acid serves as an antioxidant and helps prevent damage to our blood vessel linings, so a continual supply of uric acid is important for protecting our blood vessels. Uric acid levels in the blood and other parts of the body can become too high, our kidneys are responsible for helping keep blood levels of uric acid balanced, and kidney problems can lead to excessive accumulation of uric acid in various parts of the body. Excessive breakdown of cells can also cause uric acid build-up.

Crystals in Gout

Crystals is associated to calcium pyrophosphate and is the term used to describe a family of ions containing calcium ions combined with orthophosphates, pyrophosphates, hydrogen or hydroxide. It is the primary "ingredient" in forming bones and tooth enamel and in the calcium found in milk which helps strengthen the bones and teeth when consumed. Calcium and kidney stones are related to each other because some types of kidney stones are caused by a build-up of calcium in the kidneys. When calcium crystallizes in the kidneys, kidney stones tend to form. The type of kidney stones that are caused by calcium build-up are typically called calcium oxalate kidney stones. Oxalate is a substance the liver produces and also exists naturally in some foods and can attach itself to calcium molecules inside the body, and these occasionally crystallize and form painful stones inside the kidneys. A person who is concerned about calcium and kidney stones may believe that he needs to limit his calcium intake, but there may be some other ways to prevent the stones without cutting back on calcium, (Singh, J.A., Reddy, S.G., Kundukulan, 2011: 23 (2). 192-202).

Therefore, uric acid forms when purine breaks down. Purine is a protein which is one of the basic building blocks of life. It is found in high concentration of foods like shellfish. When we eat foods that are high in purine we process the protein to produce nutrients for life and this is a good thing. The by-product of that breakdown is uric acid which most of the time is converted to the soluble form which is a salt called urate which we excrete through the kidneys. However, for some, this conversion is more difficult, the outcome of uric acid in the system is inevitably gout which is sore. The gout attack is liken to having shards of glass in your joints and is very painful. The solution is to minimise foods high in purine and to take the uric acid converting drug allopurinol which is essentially the medication that has been around for decades, is evidenced based to be safe, and works if you take it.

A Gout Attack

A gout attack is hallmarked by elevated levels of uric acid in the bloodstream. It is marked by transient painful attacks of acute arthritis initiated by crystallization of urates within and about the joints and can eventually lead to chronic gouty arthritis and the deposition of masses of urates in joints and other sites, sometimes creating tophi. It is characterized by excruciating, sudden, unexpected, burning pain, as well as swelling, redness, warmth, and low-grade fever may occur and stiffness in the affected foot. This occurs most commonly in the toes of men but it can also affect other joints, such as the ankle, heel, instep, knee, wrist, elbow, fingers, or spine. The individual usually suffers from two sources of pain: the crystals inside the joint cause's intense pain whenever the affected area is moved, and the inflammation of the tissues around the joint also causes the skin to be swollen, tender and sore if it is even slightly touched. Elevated levels of uric acid in the urine can lead to uric-acid crystals precipitating in the kidneys or bladder, forming uric-acid kidney stones.

Dual Paradigm Approach – Whakapapa Paradigm/Clinical Process about Gout

This section investigates the systems within the two worlds: clinical process for gout, whakapapa paradigm and Māori human growth that demonstrates the intertwining of the two schools of thought, its integral components of connection, each level of thought contributing to the process of knowledge, and each complimenting each other.

Clinical Process for Gout (describing whakapapa connections)			
Chemical imbalance	**Whanau of Uric Acid**	**Whanau of Crystallisation**	**Gout Attack**
High /Moderate/Low purine foods (protein)	Heterocyclic compounds: carbon, nitrogen, oxygen, hydrogen Protein, carbohydrates fat hydrogen (water molecules)	calcium pyrophosphate: orthophosphates, hydrogen, calcium and kidney stones are related, causes types of kidney stones from a build-	elevated levels of uric acid in the bloodstream; attacks of acute arthritis initiated by crystallization of urates within and about the joints;

		up of calcium in the kidneys	elevated levels of uric acid in the urine can lead to uric-acid crystals precipitating in the kidneys or bladder, forming uric-acid kidney stones
Whakapapa paradigm (describing behaviours and characteristics of gout)			
Te Kore (limited knowledge)	**Te Po** (**voids of darkness)**	**Te Ao Marama (verbatim statements)**	
knowledge that was passed down from generation to generation; accepted these messages; did not seek further clarification **Emotions:** shame, embarrassment, hurt **Behavioural responses:** Disengagement, isolation for a period of time.	symbolised gout as been left unattended for a period of time: minimum of 5 years they suffered with gout; maintained limited knowledge. **Emotions:** misunderstood, misjudged , deep shame, deep sadness, deep anger, deep hurt Behavioural responses: further isolation, hiding the fact they have gout, making excuses for their absences from whanau gatherings/events	"*Keen to talk further how we can manage our gout. I reckon if I understand what gout is all about I can talk to my whanau. I said to my boys they are young and vibrant and clever enough to help my mokopuna that probably will get gout, I don't want my mokopuna to be silenced.*"	

	Consequences: loss of employment, loss of relationships, loss of whanau connections, loss of perceived mana		
Māori human growth and development model (the source of the behaviour)			
Te Pu (root cause) the nutrient that causes growth and potential	**Te Weu (the rootlets or the offshoots) from Te Pu, the root cause that comes off the main root.**	**Te More (the taproot or the main arterial root) that causes growth.**	**Te Aka (the vine) represents an internal process that is associated with living or the state of being alive.**
Cognitive and instinctive learning; Individuals comprehend that their inappropriate behaviour has a root cause; Adjustments in personal behaviour and lifestyle can be considered as necessary for recovery; Process of adjustments or behaviour is contingent on redressing negative influences	side issues that are related and intertwined to the root cause of behavioural influences; annoyances that generally hinder or slow the process of change and constructive growth; the real causes of behavioural problems are not identified at an earlier stage compromising the journey and or the healing process; need to address the rootlets or off shoots that are	the root that can cause a diversion in growth; nurturing and care one is able to add to the quality of life	care and protection given to the taproot and rootlets determines the quality of the vine; the physical evidence of ancestry is symbolised by the roots and thereby affirms one’s identity; this evolvement we are taught fundamental principles that give enhancement to our character, cultural identity; process of growth is activated it can give rise to the

<table>
<tr><td></td><td>seen as side issues or the root cause of behavioural influences, requires individuals to utilise their learnt skills in overcoming the stage of <i>Te Weu</i> (rootlets)</td><td></td><td>individual’s character, responsibility to take ownership of these, and in turn bring about a state of liveliness.</td></tr>
<tr><td colspan="4">Te Tipuranga (symbolising growth)
- learning and survival is dependent on the environmental elements to provide and produce nutrients for long-term survival
- access to the elements of nature, which provides the basis for further development
- shapes ethical behaviour. These are the relationships between people; between people and the physical world; between people and the atua (spiritual entities)</td></tr>
</table>

Summary

A dual paradigm approach using kaupapa Māori (Māori worldview) was framed by *whakapapa* (genealogy) paradigm of *Te Kore* (the abyss), *Te Po* (voids of darkness) and *Te Ao Marama* (world of light). This framework assisted in describing behaviours and characteristics of gout suffers and was seen as offering a wealth of concepts, principles and values that are used and applied through time. The key concepts were viewed as strongly influencing the attitudes and behaviour of Māori people today and underpin the way Māori deal with the world and influences many ideals and actions. *Whakapapa* (genealogy) is at the heart of Māori knowledge, Māori ways of knowing, and Māori ways of acquiring new knowledge. It is a framework that reaches the heart of Māori, positions thought and understanding making connections through *whakapapa* (genealogy). It is a tool to transmit bodies of knowledge through generation to generation, makes sense of the characteristics and behaviours of whānau groupings by tracing the blueprints of the footsteps of ancestors. This is a language that is mostly understood among Māori communities to enhance the wellbeing of people, as *whakapapa* (genealogy) paradigm has a purpose and reason for being; processes towards conscientisation, engage thought, reflection, interest, excitement and willingness. This in turn leads to dialogue, discussion, debate, creates reference points, creates tensions, creates challenges, encourages courage and pursues enlightenment. It has an order, a guide to live life by, a way to move forward, a plan with strategies of wellbeing, and a notion of evolving through time and an understood response to challenge. It has a process of rationalising ideas through one's deepest thoughts, having key parameters, has reasoning, logic and explanation and has a universal approach to themes from local angles. Whakapapa (genealogy) paradigm has an intent, rules, standards, and ways of doing, ethics and why and how they are created. There are many interpretations, many re/constructions and many contexts and sites. Whakapapa (genealogy) paradigm therefore, has constructions of order, cultural thinking, represented through its language, located in its structures and systems, the location of conventions and rationales. Finally, Marsden, M. (1977) asserts Māori worldview as:

> *"The centre is where he must create himself an orderly system of ideas about himself and the world, in order to regulate the direction of life."*

The Māori human development framework tracked stages of growth and development and was viewed as a process to unfold bodies of knowledge found within the *whakapapa* (genealogy). On one level the *whakapapa* (genealogy) paradigm recognised behaviour and characteristics of a gout sufferer, while the Māori human growth and development signposted these behaviours and characteristics. *Te Pu*, (root cause) signposted individuals inappropriate behaviour that has a root cause, *Te Weu* (rootlets or the offshoots) signposted side issues that are related and intertwined to the root cause of behavioural influences, *Te More* (taproot or the main arterial root) signalled the root that can cause a diversion in growth, *Te Aka* (the vine) determines the quality of the vine, *Te Tipuranga* (symbolises growth) shapes ethical behaviour and produces nutrients for long-term survival.

The second section explored the clinical process of gout through the chemical imbalances, uric acid, crystallisation and a gout attack. Of interest the clinical pathway on gout depicted a *whakapapa* order; chemical imbalance, if an individual is at risk of gout, diet was an essential key; the *whānau* purine is a protein and the whakapapa connects to food, in particular red meat and seafood. The by-product of that breakdown is uric acid which most of the time is converted to the soluble form which is a salt called urate which we excrete through the kidneys. However, if the *whānau* kidney is unable to breakdown the high levels of purine the whānau uric acid arrives, the cousins carbon, nitrogen, oxygen, hydrogen take form and the whānau crystallisation arrives. The whānau calcium and kidney stones are related to each other because some types of kidney stones are caused by a build-up of calcium in the kidneys. When calcium crystallizes in the kidneys, kidney stones tend to form and the onset is a gout attack.

The final section brings together a dual paradigm framework within the two worldviews: clinical process for gout, *whakapapa* paradigm and Māori human growth and development. This depicted the intertwining of the two schools of thought, its integral components of connection, each level of thought contributing to the process of knowledge, and each complimenting each other.

Chapter six continues the dual paradigm approach and explores *Whakamā* as a guiding principle to unearth myths about gout. It explores the origins of *Whakamā* (inner consciousness, facial/body expressions) through Māori history and mythology. *Whakamā* (inner consciousness, facial/body expressions) is considered as an important construct in order to understand the interaction of Māori with each other and its various behavioural manifestations and possible causes. A whakapapa (genealogy) paradigm using *Te Kore* (abyss), *Te Po* (voids of light) and *Te Ao marama* (world of light) will be the framework to articulate and signal signposts of *Whakamā* patterns of behaviour and states of being. Finally, discussions on *whakamā* (inner consciousness, facial/body expression) and health are reviewed from the one to one whānau/family interviews.

Chapter Six

Shades of Whakamā: Research Analysis

Origins of Whakamā

Māori history and mythology contain a number of examples connecting to *Whakamā* (change in facial/body expression). The separation of *Ranginui* (sky father) and *Papatuanuku (*earth mother) created layers of *Whakamā* (change in facial experience) among the brothers; in particular *Tawhirimatea* (god of winds) rebelled against his brothers for separating their parents and through the wrath of his wind took revenge. It is also considered when *Tanenuiarangi* (god of forests) took his daughter *Hinetitama* (first human) for his wife. When *Hinetitama* (first human) realised her husband was her father she was overcome with *Whakamā* (change in facial/body expression) and became *Hinenuitepo* (Goddess of the night). The story served to establish and promulgate the incest taboo, which was inevitable for the establishment of the human line (Walker, R. 1990: 15).

The Demi-God *Maui* became *Whakamā* (inner consciousness/facial/body expression) not because he caught no fish but because his brothers laughed at his failing, (White, J. II, 1887:63). On another fishing expedition, Te Ika a Maui brought about greed among his brothers, quarrelling over the fish and began hacking at it, the significance of this event today is the need to conduct appropriate rituals of thanksgiving for the gifts of nature. The journeys he undertook to obtain knowledge of the world, tricking his kuia Mahuika in the secret of fire making her give up her fire fingernails and toenails. The story of Rupe, who went in search for his sister Hinauri, after his brother Maui turned her husband into a dog, she was so bereft she threw herself into the sea and cast up on to strange shores. Rupe journey, he met Rehua. After the formalities of welcome were complete, Rehua undid his topknot and shook out bellbirds and tui; he caught the birds and prepared a meal of them for his guest Rupe, Rupe was disgusted. The notion of eating food that had been in contact with the head is so repulsive in customary usages of the Māori it hardly bears contemplation.

The story of Tinirau who was renowned for having a pet whale, Tutunui, the tohunga Kae conducted a tohi ritual for the son of Tinirau and his wife Hinauri; Tinirau offered his whale to Kae to ride back to his village. Kae and his tribe killed and ate the whale. The killing and eating of the pet whale introduced a basic theme of utu in human affairs, whereby revenge is correct if there is a just cause. By killing the whale that was offered by Tinirau, Kae betrayed his host’s trust. In the end Kae was killed as utu for the whale Tutunui.

The story of Tawhaki and his victories of war spread among the earth and the sky, where a celestial maiden named Tangotango, came to earth and visited him nightly. Overtime

Tangotango became pregnant, after giving birth to their child; Tangotango was insulted when Tawhaki said she child smelt when he went to perform the tohi ritual. Due to the insult she left Tawhaki and her and the child returned to the celestial realms. Tawhaki missed his wife and went in search for her. Even though Tawhaki was put through many tests the humbling experiences he had to endure at the hands of his wife's people, his brother-in-laws treated him like a slave. These trials were Tawhaki's compensation of his insult to his wife and child.

Waiho maa te Whakamā e patu,' was a *whakatauki* (proverb) bestowed upon the Ngāti Awa people from the tohunga Te Tahi O Te Raa, when translated means 'let their shame be their downfall.' Te Tahi O Te Raa was renowned as a tohunga *huawhenua* (expert of horticulture); his crops at the time were flourishing, whereby his people's crops were not. The people thought Te Tahi O Te Raa must have turned against them, as their crops were not flourishing like his. They became suspicious of him and conspired against him, wanting him dead. However they were afraid to kill him due to the status of his *mana* (prestige/integrity) and they decided to invite him to participate in a *hui* (gathering) on a deserted island, their intention was to leave him there to perish. Te Tahi O Te Raa agreed, not knowing the true intention of the people. At night when Te Tahi O Te Raa went to sleep, the people left him alone on the island. Due to the calibre of Te Tahi O Te Raa, a whale came to the shore and offered to return him to his whenua, at which Te Tahi O Te Raa accepted. On their journey home the whale saw the people that had left Te Tahi O Te Raa on the island and asked, do you want me to kill them, and Te Tahi O Te Raa replied no and recited the *whakatauki* (proverb) 'waiho *maa te Whakamā e patu.'* It is said by people of Ngāti Awa that *Whakamā* (inner consciousness, facial/body expressions) is evident today and the *whakatauki* (proverb) still lives among some of the people.

According to descendants of Ngāti Awa, unemployment, lower socio-economic factors and limited opportunities of relatives moving forward, they have aligned it to the *whakatauki* (proverb), these descendants left their *papakainga* (place of standing) in order to break what they believe held them back from their potential and to give their future generations their potential and opportunity in their lives. [13]

Research undertaken by Sachdev, P.S., Lindsay, K. (2007), Counties Manukau Māori Gout Action Group (2008), have also written on the effects/affects of *Whakamā* (inner consciousness, facial/body expression) in the context of health and the education environment. The research indicates the influence of *Whakamā* (inner consciousness, facial/body expressions) as behavioural indicators, such as;

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[13] Eric Nathan (2012. Personal communication.

> *Whakamā, or shame, is common because of the perception that the cause of gout is alcohol and overeating… Whakamā is an important construct to understand how Māori interaction with each other and with the Pakeha…The Whakamā reaction is one of extreme outward embarrassment in the face of praise, even if inside the praise is welcome…*

Whakamā and health

This experience is no different when considering *Whakamā* (inner consciousness, facial/body expression) in the context of health services. Māori patients do not generally question a Doctor or ask questions of their illness. *Whakamā* (inner consciousness, facial/body expression) is signalled by sighs, nodding, and short brief responses yes or no. In a research study conducted by Kerr, S., et. al (2009) noted both Māori and health practitioners clearly expressed concern about the effectiveness of communication within clinical systems. From the perspective of most Māori patients and *whānau* (family), service providers didn't take enough time to build relationships and Māori reported health professionals failed to listen appropriately leaving them feeling misunderstood. Health professionals were seen to create barriers, using difficult language and not discussing their decisions. They failed to take account of, or value the supportive roles of *whānau* (family) in listening and sharing information. Service users felt the poor communication could be an effect of cultural difference and some talked of discrimination against Māori.

The Construct of Whakamā (inner consciousness, facial/body expression)

The relationship of *Whakamā* (inner consciousness, facial/body expression) in contemporary society to Māori can vary in experience; *Whakamā* (inner consciousness, facial/body expression) is a word that stands for a concept that Māori use in the process of organising and talking about their experience of being human. The interpretation of Whakamā explained by Matua Bill is: *whaka* – to cause, to make, *maa* – referring to ghostly appearance, white appearance, inner consciousness, and change in *ahua* (appearance). Therefore *Whakamā* will be positioned as an inner consciousness, facial/body expression.

Whakamā (inner consciousness, facial/body expression) is experienced from seeing something that may not have been approved or supported from the *whānau* (family), something that was heard within the *whānau* (family) that made *whānau* (family) or individuals lose face, and the other if a *whānau* (family) or individual acts out something that is not approved or supported. As a result of *whānau* (family)/individual seeing, hearing, and acting, at one level there is a change in one's facial/body expression, i.e. flushed or blushes, body language signs of withdrawal, head lowers, no eye contact, and removal of oneself. The facial/body expression can be further disabling when *whānau* (family)/individuals are challenged to do something they don't want to do, seen and thought of as a show off. It is a process in a way of thinking about interpersonal relations; it can be an invasion of personal boundaries or an element of *tapu* (sacredness). Māori use the word in connection with a particular state of mind, feelings in the sense of awareness. Behavioural responses are made up of outward and visible signs and is directly observable, whereas the inner consciousness, state of feelings are inward and invisible, access to them is gained only by listening to what Māori have to say about them.

Matua Bill (2010) [14]explained in his time it was evident for the *whānau* (family) to recognise *Whakamā* (inner consciousness, facial/body expression), one did not have to speak to know the state of being that the *whānau* (family) or individual was experiencing, it was to do with *mana* (prestige, integrity). We saw that was enough punishment for the *whānau* (family) or individual to carry, generally speaking no one would talk or mention it again. There are of course *whānau* (family) who would not forgive so easily and continually reminded the *whānau* (family) or individual their wrong doings, this was a sad experience to see and bear witness too.

Furthermore, Matua Bill indicates western societies connect *Whakamā* (inner consciousness, facial/body expression) as relating to emotions like shame, shyness and so on, but what they fail to understand is that the level of w*hakamā* (inner consciousness, facial/body expression) extends to *whakapapa* (genealogy):

> *"I have known a taake (issue/concern) to extend through whakapapa (genealogy) generation to generation and even though that whānau (family) of that time they did not cause this but it still was theirs to hiki (carry). It is very heart wrenching to see whānau (family) experiencing this level of mamae (pain), Whakamā (inner consciousness, facial/body expression) has the ability to cause harm or can do well for whānau (family)."*

There are positive and negative connotations to *Whakamā* (inner consciousness, facial/body expression) it really depends on the *kaupapa* (topic/agenda). From an outsider they would not understand the depth of the impact this *whānau* (family) was experiencing. Sachdev, P.S. (1990) views of *Whakamā* (inner consciousness, facial/body expression):

> *"Whakamā is an important construct to understand how Māori interaction with each other and with the Pakeha, and to understand the behaviour in clinical presentations of some Māori patients."*

When considering *whakamā* (inner consciousness, facial/body expression) behaviour, it is diverse among Māori, every form of engagement, can be visually seen by others, but may not be recognisable to non-Māori. These behaviours are usually not considered as abnormal

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[14] Rauwhero, B. (2010). Personal communication.

and can be incorporated with *tikanga and kawa* (protocols and practices) as a measuring guide of *mana* (prestige) and *manaakitanga* (carer of, nurturer) in accordance with Māori worldview. If *whānau* (family) or individuals lack knowledge of *marae* protocols, if *whānau* (family) are unable to contribute to *koha* (giving of) and if a *haapu* (sub-tribe) does not provide *manaaki* (care for, nurture) to their *manuwhiri* (guests) the *marae* and its people will be weakened by *whakamā* (inner consciousness, facial/body expression) for some time to come. However, this may not be regarded normal by non-Māori, in fact it could have the opposite affect for those not familiar with this construct.

Ritchie, J. (1963:178) asserts *whakamā* (inner consciousness, facial/body expression) in contemporary Māori society to be in the sense of inferior, inadequate, diffident and with self-doubt in uneasy situations outside the range of ordinary events. This is evident when Māori are in unfamiliar territory and feeling threatened to perform in a Pakeha context. For example when Māori children are asked questions frequently from their Pakeha teacher; the level of *whakamā* (inner consciousness, facial/body expression) experienced range from feeling lost for words, maybe unable to respond, feeling inadequate among their peers. *Whānau* (family) struck by poverty, children experiencing *whakamā* (inner consciousness, facial/body expression) because his *whānau* (family) were poorly dressed for teacher and parent evening, in comparison with another *whānau* (family) present, (Johansen, J. 1954).

There is also the importance of interpersonal connections with *whakamā* (inner consciousness, facial/body expression) that are evident in the engagement of Māori. The interpersonal context is very important not only in causing *whakamā* (inner consciousness, facial/body expression) but also in the course it takes. Māori decision-making is generally through the collective *whānau* (family), *haapu* (sub-tribe) and *iwi* (tribe) in which *whakamā* (inner consciousness, facial/body expression) can play a significant role in shaping the behaviour and engagement of the *whānau* (family).

It is the *mana* (prestige) of the *whānau* (family) represented and their *whakapapa* (genealogy) that is significant. This engagement with *whānau* (family) causes *Whakamā* (inner consciousness, facial/body expression) and can be a positive or negative experience and can direct the course of engagement and *korero* (discussion). This concept of *mana* (prestige) Johansen states "*for the Māori, life and honour are one, it cannot be separated*."[15] Praise of a person may produce *Whakamā*; feeling shy that others are praising him/her achievements or fear that others may consider him/her *whakahiihii* (conceited).

Whānau/*family* unsure of how to respond appropriately at a *hui* or what course of action they should be taking, lost for an answer, or afraid of making a fool of themselves. *Whakamā* (inner consciousness, facial/body expression) can be passed down from generation

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[15] Ibid: 52

to generation where individuals/*whānau* (family) experience *whakamā* (inner consciousness, facial/body expression), because of some wrong doing of their children and vice versa. This occurs because of *mana (*prestige) and *whakapapa* (genealogy), the shared obligations and responsibilities for this *whānau* (family). However, *mana* (prestige) and *whakapapa* (genealogy) is uplifted when their child/mokopuna graduates at university and is more significant for the whānau if this is their first child/mokopuna to do so. There are many other examples that reflect *Whakamā* (inner consciousness, facial/body expression); the importance here indicates the depth and breadth *Whakamā* (inner consciousness, facial/body expression) signals and has the ability to create the direction and the actions undertaken.

Signposts for Whakamā (inner consciousness, facial/body expressions)

The sets of relationships that can occur in order to understand the states of *whakamā* (inner consciousness, facial/body expression) are: 'Is the person or group, *whakamā* (inner consciousness, facial/body expression) on their own behalf or on that of others?' 'Did person and/or group experiencing *whakamā* (inner consciousness, facial/body expression) incur the *whakamā* (inner consciousness, facial/body expression) themselves by their own action, or whether it was inflicted on them by others?' 'Is there actual wrongdoing involved?' The process of determining *whakamā* (inner consciousness, facial/body expression), is considering if you hear, see or do something that you feel is not right, this can be the first signpost to *whakamā* (inner consciousness, facial/body expression), what am I determined by? What are the signposts of whakamā? These signposts will be articulated through a whakapapa framework using *Te Kore* (the abyss), *Te Po* (voids of darkness) and *Te Ao Marama* (world of light).

Whakapapa paradigm (genealogy)

Whakapapa (genealogy) relationships are between people, their physical world and the *atua* (spiritual entities), this perception is similar to the *whakapapa* ethical model which Marsden, M.(1975) poses, he argues that "*it is whakapapa that enables a person to trace their descent and this identity binds the Māori world together*." *Whakapapa* (genealogy) identifies the nature of relationships with all things emphasising the responsibility owed by individuals to the collective. It provides the individual identity through the individual's relationships with others. It is the relationship between people and the environment and this sacred relationship governs the laws, which prohibit Māori from exploiting the natural world for individual profit.

The Māori philosophers saw the whole world order as a vast genealogy. The simplest genealogies were those of the common man, tracing himself from a tribal ancestor, connecting to members of the tribe depicting complex relationships. Everything in the Māori worldview order was genealogically connected. The Māori traditional belief sees the whole of creation as a dynamic movement *i te kore, ki te po, ki te ao marama*, (out of the nothingness, into the night, into the world of light). Shirres, M. (1997) contends that this is a model to understand the universe and its evolvements and that is intimately linked into both the world of spiritual powers and the material world we see around us. The following descriptor synopsis shows the philosophical and ideological themes incorporating signposts indicating behavioural patterns and states of being associated to whakamā (consciousness, facial/body expression).

Te Kore (abyss)

Te Kore (abyss) signifies the realm between non-being and being, that is, the realm of potential being. It is the realm of primal and elemental energy or latent being. Marsden, M. (1985) indicates "*it is here that the seed-stuff of the universe and all created things gestate, it is the womb from which all things proceed*." A contemporary perspective of *Te Kore* (the abyss) is used as an opportunity to identify stages of underdeveloped growth due to life changes events in one's life, in this case being informed or diagnosed with gout; individuals may find themselves in states of unknown, uncertainty and levels of scepticism.

On the surface level individuals behavioural responses may signal disengagement and isolation for a period of time. The level that cannot be seen is in the inner-state-of-being, the *wairua* (spirit). This line of thinking is supported by Durie, M.H. (1997:1-24) that indicates, "*mauri rere an unsettled spirit and denotes both change and discomfort, experienced within the spirit.*" The spirit or *wairua* for Māori can be viewed as a decision-maker, the director of the innersole where signposts of Whakamā emerge: feelings may become suppressed such as anger, frustration and feelings of hurt and pain. Metge, J. (1986:25) suggests access to understanding states of *Whakamā* (inner consciousness, facial/body expression) is gained only by listening to what Māori have to say about it.

Māori thinking can be the attribution of blame, this comes after the identification of *whakamā* (inner consciousness, facial/body expression), not before, hence the importance of the state of *whakamā* 'to be understood and addressed. The importance is to recognise the signposts of the inner-state-of-being, *mauri rere* (unsettled spirit) through; acknowledging and working through to a place of acceptance, to enable one-self in understanding gout, accepting support when needed and to take control of one's own health. If one is enabled to work through this event, the healing of *whakamā* (inner consciousness, facial/body expression) begins. However if this process does not happen it can move to another experience of *Whakamā* (inner consciousness, facial/body expression).

These states of experience provide pathways toward positive and negative outcomes for *whanau*/family. If an individual is unable to come to the place of recognising signposts of whakamā (inner consciousness, facial/body expressions), the pathway can have devastating results, not only for the sufferer of gout but also their whānau/family. These states are signalled as unresolved issues overtime that vary in the intensity experienced, ranging from slight to catastrophic, a state of discovery. Metge, J. (1986: 32-33) indicates states of *whakamā*:

> *"Can be passed on from generation to the next and have varying levels of positive or negative outcomes. It is associated with feeling uncomfortable and self-conscious; it has negative connotations, associated with ideas of dishonour; disgrace and the attribution of blame.*

Whakamā (inner consciousness, facial/body expression) behaviour may be associated by unresponsiveness that is withdrawal from communication with others. A person experiencing *whakamā* (inner consciousness, facial/body expression) displays various expressions, intensities and duration of *whakamā* (inner consciousness, facial/body expression). If the disparity that caused *whakamā* (inner consciousness, facial/body expression) and in this sense being informed or diagnosed with gout maybe a minor setback if the individual is secure in him/herself, supported by others, then he/she would more likely get over it fairly quickly. It is vitally important that other people recognise the condition for what it is and act to help with recovery. Metge suggests in these cases *whakamā* (inner consciousness, facial/body expression) may pass without lasting ill effect, if allowed to linger unhealed it becomes permanently ingrained and can fester to a chronic state.

The signposts may vary in the degree of *whakamā* (inner consciousness, facial/body expression), for the more serious situations, an individual will remove themselves from the scene entirely, and in some cases followed by the family. It may lead to cutting off with the community and the individual remains withdrawn to some degree. The extent to which they recognise and work through this process with other people varies with their personal sensitivity, the wisdom with which their own *whakamā* (inner consciousness, facial/body expression) experiences have been handled. It also involves the extent to which they have been able to bring it to conscious awareness. In some cases people can misinterpret the signs of *whakamā* (inner consciousness, facial/body expression) and repeat the behaviour that caused the *whakamā* (inner consciousness, facial/body expression) by placing blame on others and accepting they have no control of managing gout.

Therefore, *Mauri rere* (unsettled spirit) has not been acknowledged, and may advance to negative feelings or suppression. In order for the healing process of *whakamā* (inner consciousness, facial/body expression) to begin, the individual must enable one-self to understanding gout and accept support when needed. If there is no acknowledgement of this, it could lead to another level.

Te Po (voids of darkness)

Both *Te Kore* (abyss) and *Te Po* (darkness) signified the emptiness and darkness of the mind, because there was limited light and knowledge. It is the intangible, unknown and unseen that denote phases of darkness. From a personalised viewpoint *Te Po* (darkness) symbolises gout as being unresolved there is limited vision and limited light. For gout sufferers, this can be the time when their goals and aspirations are neglected or discarded because of the desire to seek relief for a disease that they do not want or understand. Time and energy is invested in the denial process associated with grief, this is the darkness with no understanding.

Where there is no understanding and limited knowledge about gout, individuals can experience further displacement within their inner-being, the *wairua* (spirit). Durie, M. (2001) suggests *toko mauri* (break of continuity, displacement of energy and vitality), creating an unbalanced spirit. In the context of this situation *whakamā* (inner consciousness, facial/body expression) has been left unattended for a period of time, in some cases the consequences can be extremely damaging for the individual and for their whānau/family. Gout sufferers are likely to find themselves in the company of people who do not recognise the condition and do not know how to help, (Metge, J. 1986:119-22). When *whakamā* (inner consciousness, facial/body expression) is continually reinforced in this way, it becomes ingrained and chronic, involved in everything the person does, permanently impairing his/her image and affecting his/her attitudes and relationships with others. When *whakamā* (inner consciousness, facial/body expression) goes unhealed, and where the gout sufferer conceals it, it can lead to a breakdown in a person's wellbeing.

Metge, J. suggests when sufferers of *whakamā* (inner consciousness, facial/body expression) become chronic; they may become under-achievers, beset by feelings of being misunderstood, misjudged and unloved.[16] In the case of gout, this could signal loss of employment, loss of relationships and isolation as gout has not been managed effectively. The individual may brood over real and fancied injustices and their own powerlessness. If the individual cannot find an outlet for their frustration, sooner or later they may explode into violence. And that violence is directed at whoever gets in the way, whether or not they are personally involved.

The individual who is suffering from this intensified state of *whakamā* (inner consciousness, facial/body expression) interacts with a variety of relationships. These can be

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[16] Ibid: 122

individual or collective and have variable connotations to that individual, these relationships maybe either positive or negative. Depending on the intimacy of the relationship, this determines the direction of where *whakamā* (inner consciousness, facial/body expression) will go, whether the person wants to continue the relationship with the person who is *whakamā* (inner consciousness, facial/body expression)*?* Whether or not that person is in a state of *whakamā* (inner consciousness, facial/body expression) themselves? And what the outcome will be? Whichever angle you take, the state of *whakamā* (inner consciousness, facial/body expression) can cause havoc and affect personal and group relationships. Furthermore, if the state of *toko mauri* (break of continuity, displacement of energy and vitality) continues, the relationship with oneself may be affected, in the sense of not taking care of oneself.

Therefore, *toko mauri*, (break of continuity, displacement of energy and vitality), requires recognition. Acknowledging and working through to enable one-self, accept support when needed and to take control of one's own health, the process of *whakamā* (inner consciousness, facial/body expression) begins. If unresolved, *whakamā* (inner consciousness, facial/body expression) intensifies.

Te Po Wha Wha in its traditional view is the night of feeling, descriptively both physically and spiritually. From a personalised viewpoint *Te Po Wha Wha* is the time when the senses are seriously restricted, and therefore the fifth sense of touching becomes predominant, however this is a temporary occurrence; requires the process of finding one's way, and the process of balance. In this instance the emphasis is on the physical feelings, as to the spiritual aspects of feelings, it is in the realm of the hinengaro (mind), puku (abdominal region), and *manawa* (heart region). The healing process required is to recognise the problem, not to minimise it nor pretend that it does not exist. For some people, they require a stage of investigating the extent and causes of their *whakamā* (inner consciousness, facial/body expression), recognising not only what is ailing them but also those aspects for which they themselves are responsible, take what action they can for themselves, and accept the help offered by others where appropriate. Metge, J. (1986: 142-4) implies:

> "*if you suppress problems and maintain that all is well, it indicates that you are retreating into a defensive position, which in turn suggests that the individual tends to hide the real causes of their problem.*"

If unresolved, the individual may experience a stage of spiritual and physical exhaustion. Te Orohi Paul (2010) refers to this process, as *Te Po Tahuri atu*, (the night of restless turning), the restlessness is subjective, and is indicative of the mental state of being.[17] Drawn from the regions of *hinengaro* (mental ability) and *wairua* (spirit), the process of

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[17] Paul, T. (2010). Personal communication.

restoration is contingent on how much one wishes to let go or surrender or forgive. It is often described as a *wānanga* stage, that is “to worry” an issue, to pursue an issue. It is the time for the process of *Whakamā* to begin ‘to cleanse’ the domains of the mind, body, spirit and *whānau/family*, as they are not separate entities however they are interlinked to capture the concept of wholeness. The connection of *Te Po Tahuri Atu* (the night of restless turning) and the gout sufferer links to time and energy being invested in the denial process which is generally articulated alongside grief, behavioural patterns continue to emerge, disengagement from whānau, isolating oneself, states of feelings: misunderstood and not heard, outburst of anger, blaming and self-indulgence, self-pity and feeling abandoned.

What can be done to begin the healing of *whakamā*?” An individual may go through many experiences for the healing process; on a personal note the process may take the journey of ‘te *po-namunamu-ki-taiao’* (the night of seeking the passage to the world). The emphasis is on the “seeking” where there is a realisation that comes to every human being, whether Māori or non-Māori, sooner or later it is time to move on. Finding a passage to reality is an exhaustive process that constitutes a new journey. A positive expedition is found when one is assisted carefully through a process of self-evaluation and the ‘what have I learnt through this experience’ syndrome. A negative expedition is found, when one is an unwilling participant to moving forward. The passageway can become clearer or cloudy dependent on the individual’s capacity to make constructive decisions.

Whakamā and Te Ao Marama (the world of light)

It is the moment of ascension from darkness into light, one that is fundamental to the health and well being of every individual, even if this process is for a short period of time. It is the gasp or sudden intake of breath referred to as ‘*Tihei mauri ora’* (breath of life). The important focal point is to come to a place that Durie, M. (2001) suggests as ‘*mauri atawhai’* (nurturing and supporting of the spirit), this process will ensure the status of *‘whakapiri mauri’* (the restoration of the spirit) and ‘*whakahokia te mauri’,* the return of vitality and spirit. It is also important to remember that the healing of *whakamā* (inner consciousness, facial/body expression) involves several stages that cannot be omitted or hurried through. It begins with those who want to be in a place of healing, support that conveys *aroha* (love, respect) by their physical presence and contact. The break through comes when those who have been instrumental in the healing process, recognise their part in causing the situation and reach out literally and figuratively to the individual/s who are in a state of *whakamā* (inner consciousness, facial/body expression). Metge, J. (1986: 146-7) suggests full recovery is achieved only when he/she is restored to his/her proper place.

Regardless of the state, the level of interaction, and the intensity of the state, it requires acknowledgement, recognition and acceptance to be able to deconstruct the challenging tensions that exist and reconstruct the process to learn, and move forward.

Whakamā as a guiding principle to unearth myths

Whakamā (inner consciousness, facial/body expression) was the guiding principle that unearthed myths and states of being relating to gout. Kaupapa Māori and participatory action research provided the appropriate process of engagement with participants. The themes that arose from these interviews either disabled engagement where they did not seek support for gout or enabled engagement where they managed their gout. The majority of these interviews highlighted the signs of *whakamā* (inner consciousness, facial/body expression) and were aligned to the myths 3,4,5, identified from the Counties Manukau District Health Board Māori Action Research Group noted in Chapter one.

The interviews were a reflection of lived experiences and the stories about gout that were passed down through generations. The stories shared among whānau/family raised the state of whakamā (inner consciousness, facial/body expressions) to the point of disengaging from health care services. The perceptions about gout and the influence of environmental and behavioural factors gave rise to a feeling of powerlessness for whānau to change outcomes. Most commonly, however, the whānau/family viewed gout a ‘shameful disease’ as a major contributor that limited them in discussing with their General Practitioner or health provider. They talked about how crippling this disease was and associated with life events like social activities, *whānau*/family activities, unemployment and financial hardship but also loss and grief for those sufferers who had lost body parts.

The environment of health care services, *whānau*/family spoke of the many changes that have occurred has been positive in their General Practitioner and health care services, but still made reference to this environment being unfamiliar territory of accessing services. The participants spoke of limited information provided to them from their health provider and information that was not explained well. When asked ‘why they did not ask their health provider to explain it better,’ majority indicated, ‘too embarrassed.’ This further supports *whakamā* (inner consciousness, facial/body expressions) as a disabler that limited some of these participants to seek support from health professionals.

The one to one interviews consisted of fifty *whānau*/family (participants): thirty were individual sufferers of gout, and twenty *whānau* support. All interviews consisted of one or more sufferers of gout and several *whānau* support (view breakdown of whānau interviews) that shared their experience of living with gout. The participants also completed the pre and post *whakamā* (inner consciousness, facial/body expression) questionnaires.

The common themes that arose, were thirty-five whānau to some degree were disabled within the state of *whakamā* (inner consciousness, facial/body expression) and did not engage with health professionals about gout. Fifteen whānau were enabled and were receiving support and managing their gout. These results contributed to understanding the depth and breadth of *whakamā* and its significance in the *whakapapa* (genealogy) model about gout.

During this process lots of attention inevitable led to dialogue because that is the one way they learnt about each other and their roles within the context of this research. The detail of communicating through verbal and non-verbal (body language, spiritually) was inclusive and signposted behaviour indicators that gave rise through the process of respecting each other enough to want to hear what one had contributed. Accepting others as they are, without wanting to change or reshape them to suit us, to acknowledge whānau (participants) values, beliefs, cultural identity and who they want to be; valuing their contributions, inputs and genuinely listing to others and sharing their concerns.

Whakamā and a Methodological Framework

The process undertaken in the one to one interviews used kaupapa Māori (KMR) and participatory action research PAR). The rationale of using a dual paradigm approach was that kaupapa Māori research naturalises Māori epistemologies, methodologies and practices so that Māori are not articulated as the ‘other’. PAR works in empowering participatory ways (Reason, P., Bradbury, H. 2006) to generate research based solutions to problems that impact on the well-being of the people and communities. It focuses on participation and change, using qualitative, quantitative or mixed methods depending on the issues and context, in cycles where each revolution consists of planning action, implementing change and evaluating the results, creating new and/or confirming knowledge in the process of solving problems becomes the basis for further actions (Khanlou, N., Peter, E. 2005).

The method used in the research was based on *tikanga* (customs and protocols) and kawa (practices). *Tikanga* (customs, practices) informed and guided the process that identified layers upon which to place Māori thinking and reasoning in a culturally appropriate manner. Each component of the framework had its own *kaupapa* or purpose in this context and was framed by fundamental principles in the notions of *whakanoa* (to clear) ensuring the pathway was cleared correctly. These areas included whānau a little apprehensive and uncertain of their korero (discussion) being understood, *whakatau* (formal greeting) ensured the process of greetings providing the space it deserves, such as *whakapapa* (genealogy) connections.

The philosophy of *tikanga* (protocols) embraces new ideas, new technologies and new strategies of leading. Collective talents, expertise and energies need to be fully harnessed from across Māoridom as a whole. In this way such activities contribute to the survival, the continuity and the future development of Māori culture and identity. As noted previously, *tikanga* (protocols) are *iwi* (tribal) specific and activities will be carried out according to their *tikanga* (protocols) and *kawa* (practices).

Whakanoa process

The method of *whakanoa* (to clear) required *kanohi ki te kanohi* (face to face) meetings with *whānau/family* in an environment that was comfortable for participants, the preferred environment was to *hui* (discussions) in their homes. During this process the purpose of the research was explained and all relevant documentation was discussed. On completion of this process options were offered in relation to timeframes for the one to one interviews and four noho to assist in the development of a *whakapapa* model about gout.

There was a two-step process in terms of the meetings with *whānau/family*. Each *whānau/family* grouping were asked three questions relating to their understanding of *whakamā,* secondly, to share their stories of living with gout. The whānau were coded as Whānau and then a number (Whānau 1, Whānau 2). The use of a pre questionnaire (see Appendice One) about *whakamā* (inner consciousness, facial/body expressions) was used to ascertain the level of knowledge whānau understood about gout and a post questionnaire (see Appendice One) on completion of the four noho to gauge a paradigm shift of thinking between a medical model of treating symptoms to *Te Ao Māori* (Māori worldview) thinking about the disease gout.

The *whakatau* process (formal welcome) were concepts of *whakawhānaungatanga* (inter-relationships), *karakia* (prayer), *kapu ti* (refreshments) and *kotahitanga* (unite as one). The purpose is to *whakatau* (formally welcome) all participants including the researcher into the space of this research, to acknowledge contributions to the *kaupapa* (research) and to connect *ma ta waka* (different Māori canoes gathered for this occasion).

Tainui *tikanga* (customs) and *kawa* (protocols and practices) was the framework to articulate and set the process of engagement for the researcher and participants from *Te Ao Māori* (Māori worldview) positioning. Tainui contend that if the *tikanga and kawa* (customs, protocols) is followed correctly it asserts *whakamana* (high regard) for the *tangata whenua* (people of the land). Hosting is an integral part of *tikanga* (customs) that demonstrates *manaakitanga* (host responsibility), which is the principle of the quality of caring, kindness, hospitality and showing respect for others. This is the concept of *'whakawhānaungatanga,'* (inter-relationships) for individuals to be able to connect by *whakapapa* (genealogy), to feel part of the *kaupapa* (philosophy) and to be included.

This process was undertaken in the home of whānau/family, led by whānau, the researcher was welcomed, *karakia* (prayer) commenced the engagement, mihi (greeting) was offered, and a *kapu ti* (refreshments) completed the formal welcome. The entire ceremony facilitates the process of *kotahitanga* - that is, joining *tangata whenua* (people of the land) and *manuhiri* (visitors) as one. The process of *whakanoa* (to clear) provided safe passage for the *whānau/family* and the researcher to participate in, *whakawhānaungatanga* (inter-relationships) joined *ma ta waka* (different Māori canoe's) and *tikanga and kawa* (customs, protocols) provided a template for correct practice to be adhered to.

The below (table 1) indicate the fifty participants in this research. The heading **Whānau** represents the whānau/families participating in this research; **No. present** represent, is the number of whānau participating, **WM** represents how many whānau support is participating, **GS** represents the number of whānau who suffer from gout, **enabled** represents whether the gout sufferer is enabled and managing their gout prior to the research and **disabled** represents the gout sufferer/s have limited understanding and support for their gout.

Whānau (participants) in the Research

WM: whānau members, GS: gout suffers, enable (managing gout), disabled (limited support)

Whānau	No. present	Whānau	No. present	Whānau	No. present
1	WM:2 GS: 5 3 enabled 2 disabled	4	WM: 4 GS: 8 (enabled)	7	WM: 3 GS: 2(disabled)
2	WM: 1 GS: 2 (disabled)	5	WM:2 GS: 2 (disabled)	8	WM: 2 GS: 3(disabled)
3	GS: 2 (enabled)	6	WM: 6 GS: 6 (disabled)	Total no WM: 20 Total no GS: 30	

In total there were thirty gout sufferers; twenty seven were Māori male and three Māori female, ages ranged between mid-twenties to fifty+. There was thirteen gout sufferers identified as being enabled, they were managing their gout prior to the research. Seventeen gout sufferers had limited understanding and support prior to the research. The participants were supported by whanau members totalling twenty, with the exception of whanau 3.

The Interview Process

Below are the results for the pre-whakamā questionnaire (see Appendices One), *whānau* (participants) verbatim responses to their experience of living with gout and concludes with the post-whakamā questionnaire, (see Appendices One).

The Findings Pre-Whakamā Questionnaire

The results from the questionnaire identified a number of emerging issues to consider further in the analysis of the research. The whānau (participants) were asked three questions to gauge their level of understanding about whakamā and whether whakamā was a contributing factor for them either seeking or not seeking support form a health professional for gout. The rates were determined by level of understanding about the concept of whakamā and were rated by the individual whanau (participants); **limited** referred to little understanding on the concept whakamā, **somewhat understanding** referenced little known understanding about the concept whakamā, **good understanding**, understands the concept of whakamā, **very good understanding**, makes connections to the concept of whakamā and **excellent**, connects the concept of whakama to everyday life.

Question 1 (a) what does whakamā mean to you?

- 48 participants responded to rating 2 they had ‘somewhat understanding on whakamā’ and 2 whānau (participants) responded to rating 4 ‘very good understanding on whakamā’.

Question 1 (b) Do you think whakamā has contributed to you getting help from a health professional for your gout?

- 48 participants stated “they were unsure if whakamā contributed to them seeking help,” and 2 participants stated “yes.”

Question 1 (c) Do you think whakamā has contributed to you not getting help from a health professional for gout?

- 48 participants stated “they were unsure if whakamā contributed to them not seeking support,” and 2 whānau (participants) stated “yes.”

Question 2 (a) Do you think whakam āhas had an effect on you?

- 48 participants responded to rating 2 that "somewhat understanding of how whakamā affected them" and 2 responded to rating 4 "very good understanding of how whakamā affected them."

Question 2 (b) Due to this affect, do you think whakamā has contributed to you getting help from a health professional for gout?

- 48 participants stated "they were unsure if whakamā contributed to them getting help from a health professional," and 2 participants stated "yes."

Question 2 (c) Due to this affect, do you think whakamā has contributed to you not getting help from a health professional for gout?

- 48 participants stated "they were unsure if whakamā contributed to them not getting help from a health professional," and 2 participants stated "yes."

Question 3 (a) As a result of how whakamā has affected you, do you think whakamā has contributed to you getting help from a health professional for gout?

- 48 participants stated "they were unsure if whakamā contributed to them getting help from a health professional for gout," and 2 participants stated "yes."

Question 3 (b) As a result of how whakamā has affected you, do you think whakamā Has contributed to you not getting help from a health professional for gout?

- 48 participants stated "they were unsure if whakamā contributed to them getting help from a health professional for gout," and 2 participants stated "yes."

From whānau (participants) responses, 48 indicated they had somewhat understanding of the concept of whakamā. They related whakamā only to a feeling state "*shame, burden, anger*," and had limited understanding of the concept of whakamā and its connection to gout; while 2 whānau had a very good understanding of the concept of whakamā and could relate this to gout. This has led to the next stage of the process offering insight to the respective whanau discussions. Of particular interest were the real life experiences of whanāu living with gout.

Whānau (participants) Verbatim

Can you share your experience of living with gout?

Whānau 1 verbatim *(GS: 5, WM: 2)* – 3 enabled, 2 disabled 5 male

> *In our whānau we've had it for a long time, from our Koro, uncles and cousins, don't know if our female cousins have it, but the male do. We are cousins and this is my wife and my cousin's wife as our whānau support… I will start talking and if you want to jump in (indicating to the whānau). We don't say the word 'gout' it's a tapu (sacred) word for our whānau, but we know if someone has it. When we require tablets it is indicated through non-verbal communication with each other, a certain raise of the head, an eye movement, or we'll say cuz got the tab… It's like a secret code that only we know what it means, we can read the body signals and the tablet is left in the letter box. The medication is only used when we have symptoms of an attack; some of our whānau/family is on allopurinol and voltaren, me and of my two cousins members (pointed to the cousins). Our whānau see gout as a burden, a shameful disease, knocks our man-hood, we can't show our vulnerability or how much it hurts, and you just handle it.*
>
> *We never use to talk about it as a whānau, it was me that said to my cousins (after 5 years) hey we need to talk about this… I went to the Doctors and spoke to him about it, he gave me some pamphlets and we had abit of a korero about gout and said put me on allopurinol, I should have done this a long time ago. I monitor my kai/food that I eat, mussels do it for me, and I can say I haven't had gout for ages, use to have gout at least twice in the month. I got my whānau (cousins) to talk about two years ago and got them to say gout, not sure were we got this kaupapa that gout was tapu, I believe that kupu tapu stopped us from talking about it and the years of hiding the shame of this disease kept us in a bubble cause of it.*
>
> *Now I got my whānau (two cousins) to go to our whānau doctor and we are all on allopurinol except those two cousins (pointed, they not so convinced tables are good for them. So if you can help us help them, give them some more details about gout maybe they may have a fruitful life instead of living with pain. We will support our two cousins so count us in for your research.*
>
> *We not so convinced (two cousins not seeking support) it's having to take the tablet for the rest of your life, is that a good thing? We haven't moved much from what our cousin was talking about, the shame of this disease, the burden it creates, having to take time off work, ringing the cuz for the tablet, we still use the secret code non-verbal, the only ones we have kind of talked to are them. We keen to talk further*

with you about how we can manage our gout, we not sure what sets off our gout or why we don't just do what our cousins have done, go on the tablet, so keen for you to help us here.

Whānau 2 verbatim *(GS 2, WM 1)*2 disabled 2 male

(GS1) Gout has been in our whānau/family a very long time, my dad would isolate himself from the whānau; it could be up to a week sometimes before we saw him, even though he was in the next room. He would not let anyone come near him, just mum, it was horrible to know that my dad was in so much pain and there was nothing anyone could do, we'll that's what we thought anyway. When I got gout I was in my early thirties and I did exactly what my dad did, I isolated myself. My wife said to me one day enough is enough go to the doctors and get this sorted, of course I was reluctant because that is not how my dad did it, you know, men folk handle it. It was a disease that silenced us; kept us in a state of Whakamā, I was too embarrassed to say how much gout really hurt, it was not manly like to say it hurt, it was something you kept to yourself. This state I think was due to many factors, little knowledge about gout, and the stereotype of men just handling it; don't show your emotions, the man is the head of the whānau/family. These are just some of the things that living with gout does, it's not easy, and you just get on with it. I kind of talked to my doctor about it, he told me I had gout but haven't really done anything to manage it, I use voltaren, and it does help. What I really want to know is what sets my gout off and how can I make it stop, if there is such a thing. To be truthful I don't know why I just don't go to the doctor and have it sorted like my wife said… maybe we can talk about this as well?

(GS2) *I'm his cousin and same like him it's been in our whānau/family for ages, my dad got gout, some of his brothers, not sure if any of the aunties get gout, my sisters don't. I remember my dad been like in his thirties when he had this pain he never experienced before, he just took some tablets and went to work but I do recall him talking to mum about how painful it was, he was a labourer on the building site, so he had to have all his body parts in action, you know what I mean, hands, legs, brain thinking clearly. My dad started having this pain a lot in the end, but he never went to the doctor, he reckons he can handle it. My mum got sick and tired of his grumpiness and yelling heaps so she told him to go to the doctors or sleep in the spare bedroom. My dad reckons he went to the doctors but I don't think he did, when he got the pain he would go into the bedroom and stay there until it got better. Eventually after my dad put up with it for gosh I don't know how many years, he went to the doctors and the doctor told him he had gout, he got some tablets and was sent* *on his way, the doctor gave my dad some pamphlets, as if he would read it, so I don't think my dad really understands about gout.*

As for me, well I am the same as my cousin, we share tablets when we get the gout attack, so I wouldn't mind knowing about how I get my gout? Can I stop gout? And how does the food/drink work with gout? I reckon if I understand what gout is all about I can talk to my whānau as well and bring them out of this shame we think gout creates.

Whānau 3 verbatim (GS: *2)* 2 enabled male and female

I'm going to tell you a true story about how I realised I got gout I was in my late sixties, when I was getting help from a nurse, she would come and dress my mamae on my leg. One of her visits I invited the nurse to stay for a cup of tea because I wanted to talk to her on my own, my wife had gone shopping. I told the nurse I had gout but I never told the doctor about it, I knew I had it because I remember my whānau had it, my dad, Koro and some of the matua (uncles), so I knew it was gout and my whānau told me anyway. I think I got gout in my thirties, the pain, gosh I thought I was going to die that's how painful it was. But my whānau said no you not going to die just take these pills and you will live. So I just put up with the pain for over 30 years now. I think back on it and I'm luck my wife didn't leave me I wouldn't blame her if she did I wouldn't even stay with me, you know what I mean girl (researcher). Anyway I told the nurse I go to the pill shop (pharmacy) and buy over the counter anti-inflammatory pills when I have the pain. It really crippled me for a long period of time, put me out of action as to speak. I figured out my gout was triggered when I ate oysters, sometimes if I ate too many I would end up in bed for at least a week in agonising pain and my wife would take care of me.

Overtime my wife got gout in her late fifties and I felt so bad to think my wife had got this disease that was a feeling I have never forgotten. I felt real burdened and guilty because I thought I had given my wife gout and I thought I gave it to her through intimate contact, I carried this for a very long time. I asked the nurse, "did I give my wife gout through sexual contact?" to my relief the answer was no. You know from that day on the burden and guilt was lifted from me, I felt like a new person again, like I was purified and given a second chance. I think about that story girl (researcher) and my wife and I laugh about it. I haven't had gout for awhile now both my wife and I we manage our gout well with the help of the doctor.

Now those questions about Whakamā, I would never have thought about how Whakamā can affect our being in so many ways not just gout but all facets of our whānau lives. I can tell you this when I think about my story I can tell you exactly *where Whakamā had affected me, is when I truly thought I gave my beautiful wife gout, well lucky for me I didn't. It was over ten years before I realised I didn't, this kaupapa on Whakamā girl (researcher) I reckon you are on the right track to helping our people. If my story will help the whānau then you share it and when you get to the whakapapa model come and see us and we will help you.*

(Wife)*My husband is a lovely man, I felt so aroha for him when I realised he held that burden and guilt for so long. I was lucky in the sense I went to the doctor and he confirmed I had gout, I asked lots of questions about what this mamae is and I did whatever the doctor said so I didn't have this pain. I would tell my husband to go on the tablet because it would help him, but as he has told you after 10 years he did. Even in this time, we didn't really talk about gout because we both got it, so we knew how painful it was, and we would look after each other when we had gout. So kotiro (researcher) we take care of ourselves, but like dad (husband) was saying we would love to help you with the whakapapa model about gout, you come back anytime.*

Whānau 4 verbatim (GS: 8, WM: 4) 8 enabled all male

(Eldest brother) *Our gout has been diagnosed by our doctor for many years now. In total those in my whānau who have gout is 8, so that is all of us here today. So in this hui are my two younger brothers, me, my three cousins and my two uncles and our whānau support is my wife, my two sister-in-laws and my uncles wife, my cousins don't have wife's or partners they too ugly. Our ages range from 35+ to 55. It is a horrible disease, when I got gout I had at least a few days off work, just depends how severe it was. I told my boss at work so it made it a little easier for me when I was away but no one else knew, it's not their business anyway. We never use to talk about gout in our family its one of those things we just sort it out ourselves, go to the doctor when need be and usually our own whānau takes care of us.*

I have been admitted into hospital a few times for my gout, the staff there had made comments like 'did you drink too much alcohol Mr… Did you over eat seafood Mr… I felt real stink, you know when you asked about Whakamā it was exactly that, I was shamed man!!! because most of the time I didn't even eat heaps of kaimoana or drink, they just assumed that's what happened, but I was in too much pain to even tell them too get lost. I just couldn't wait to get out, that environment was horrible. But there were some good staff that really did want to help, they gave me some information about gout and said for me to ring them if I needed to ask questions or go to my doctor. It's just some staff that made my stay in hospital a horrible one.

I think it was about my second or third time in hospital that made the change for me, just had enough of been in pain, so I started talking to my wife about it. We *did a little research on line, got some of the whānau over and we had a hui, cause the most important thing in my mind was our kids. So we thought if we can learn about gout we can teach our whānau so they don't have to feel shamed about it, or hide away cause of the hospital staff or even our whānau laugh at them cause they're limping. The whānau as well use to say ooh you got on the booze again, you only have yourself to blame no sympathy from me cuz.*

(Cousins) *You know how you were talking about the shame, well that was us too cuz, the whānau would laugh and it made us worse, they would say the same thing, ooh yeah on the piss again cuz, okay there might be some merit in that, but hecka give the man a break!!! It's hard to talk about the pain I reckon when you a man there's this societal norm that men are the head of the house, they strong can handle pain you know what I mean aye whānau (reply yeah bro). So I reckon the shame held me back from talking about it.*

*(**Uncles)*** *well we're not that far in age from our nephews, but nevertheless we should led by example, we should have pulled the whānau together for this hui, mind you there's a few kaupapa apart from this one on gout that as a whānau we need to hui on. Our father did exactly what we did in the beginning when we got gout, we said nothing, handled it, put up with the pain, and felt shamed about having it. But when the nephew called us about the gout in the whānau this was a good opportunity to address some of the taake that we have been silenced by. Back in the days our whānau didn't talk about kaupapa like this or any other kaupapa that was affecting the whānau, but hey this is a new generation, new times and we do talk about kaupapa now, it's awesome aye whānau (reply aae). So now as a whānau we have educated ourselves about gout we manage it well actually, if you had come a few years ago (speaking to the researcher) you would have been just the ticket. Were keen to help with the whakapapa model, if that's cool by you, we got some useful tips.*

Whānau 5 verbatim (GS: 2, WM: 2) disabled female and male

My wife and I have gout and our two daughters are our whānau support, we probably had it for over 5 years or so we both in our forties. ***(Husband)*** *I got gout in my thirties, gosh it was such an agonising pain, I couldn't tell you what it feels like but can say it feels like tiny pieces of glass in my big toe and knee. I told my wife about it and she told me to go to the doctors, I never did, instead I went to the pharmacy and told them I had pain in my toe and knee and it was all swollen, the pharmacist gave me voltaren, she also said it sounds like you have gout and encouraged me to go to my doctor, but again I never did. A few days after taking the* *medicine I felt much better, so I thought that was it, but a few months later I got it again so I got me some more voltaren and it went on like that for a few years.*

I did talk to a bro at work one day and he said I got gout, cause he gets it, I asked him what he does to fix it and he said he just takes voltaren and handles it because there's nothing you can do about it. We never spoke about it again, you know when men experience pain we don't kind of poor our hearts, like women do (whānau laugh) I kept quiet because if I was to say hey it hurts, he might have mocked me, no way am I gonna look dumb or weak. It is embarrassing, somewhat shameful, my mate handled it so why can't I, and I didn't want the doctor to think I'm weak or something like that, I have my wife to support me and our daughters So that's what I have been doing just taking my tablets.

***(Wife)** Well women I think are lucky we can talk about the pain, my husband got gout first so when the pain came for me I knew it was the same as him, we compared notes as to speak. The pain well its hard to describe, the closest pain I think is giving birth, but at least when you have your baby the pain's gone, not gout it lasts a few days or so, its like been in labour forever. I asked my mum about it and she said my dad got gout, I asked what he done and why am I not surprised nothing, so my husband and I support each other and our girls help us too.*

You asked us about Whakamā, didn't really think about it until you asked. For me, it wasn't as bad as a woman talking about it, I guess there was a little embarrassment in it, but it was more the not knowing that got me. I guess like a burden you know because I didn't know if you could die from it, that was the biggest worry for me, why didn't I go to the doctors about it? I had more important things to worry about in my whānau with tangi and things like that, than to worry about myself, my whānau are important to me so I guess there sickness takes precedence. When we saw your poster we thought why not it won't hurt and here we are. We want to understand this disease? Why we get gout? Can we stop it? So cool we would like to meet with you to talk about gout further and also the whakapapa model too.

Whānau 6 verbatim (GS: 6, WM: 6) – disabled 6 males

We are all brothers and our wife's are our whānau support, there are a couple of years between each brother, I am in my fifties and we will all say our bit on gout and I will start first. I remember when I was young and we would have whānau gathering like tangi, reunions, birthdays, unveilings things like that, I always wondered why at times the uncles would be so grumpy I just thought it was them. My uncles at times would sit on the chair round the hangi pit or at the back where they *would cut up the pig and tell us younger ones what to do, in some ways they were teaching us about the marae protocol to ensure kai is served for our whānau.*

I distinctly remember a time with my uncle; he got up off his chair to show us how to do the stones for the hangi and one of my cousins accidentally stood on his feet. My uncle yelled at my cousin and said watch what you're doing? He left limping and I never saw him again at that gathering. There are a lot of my uncles that did that, I would hear them chuckle and say to each other just take those tablets and have a beer you be right cuz. My aunties would say what you think you're a doctor now go get it sorted, or other whānau would say you got gout; you drink and eat too much. I didn't think much about it you know been a young fella and all.

I was very sporty in my younger days and played up until my mid-thirties when I hung my boots up, that was because I couldn't keep up with the young fellas. I use to get a lot of pain in my joints, knee, ankles, big toe and I just put it down to the rugby injuries. I went into the A&E department a lot and they told me it was also related to rugby, so never thought anything more about it. I took heaps of voltaren because it started getting worse more towards my late twenties, early thirties. When I finished rugby I still got the pain so I went to the doctors about it and after a few visits my doctor told me I had gout, he gave me some info, more voltaren and sent me on my way, so that's how I found out I got gout, my doctor also said all those times I went into A&E it was highly likely I had gout then. When I think about my uncles I reckon they too had it too.

When I was told I had gout I got really angry, I didn't really know how bad this disease was, I didn't know what it meant for me having gout. When my brothers told me they had gout, I thought it must be a whānau curse or something cause it really cripples you. You can't think properly cause of the pain, I got angry and frustrated cause I got laid up in bed, I couldn't even have a sheet over my foot cause it was so painful. I really didn't think about how it affected me the gout I mean and when you asked those patai about whakamā, that makes sense to me. That feeling state, I can tell you when you have gout it plays with your mind, all you think about is the level of pain and I tell you on a scale of 1 to 10 when you get gout its 100. Lucky for me my wife has supported me, but really haven't thought about dealing to it, well not until I saw your poster. So for me yeah need to learn more about gout. Even though there's heaps of info out there on gout you have to be a genius to understand what they talking about, even when people that know about gout talk to you it might as well be in Japanese cause I still don't get it. So keen to have some more korero about it and yeah I want to help contribute to the whakapapa model on gout.

(Second eldest brother)*Yeah the bro's pretty much covered everything, its abit hard talking about the pain, people say in today's world its okay to talk about your feelings and everything, well its abit hard for me. I guess if I was too think of a word or two to say what it's like living with gout? I would say its terrible, it's crippling, it's shameful, we share our voltaren, we just ring each other and see who's got enough to share, and I have never been to the doctors for it, so keen to also be part of this kaupapa.*

(Third eldest brother) *Same as the bro's, I hate it when I get it, I can't even describe what the pain is like, I can't have anything over you too, I get mine in my knee and toe. I can't sleep properly, it's not a mamae that you go out and share you know it knocks the manhood abit, I just handle it, also in to your kaupapa.*

(Fourth eldest brother) *They pretty much covered everything for me, yeah it is shameful because it takes you out of commission, I can't play with the kids or join in whānau gatherings cause of it. I told my wife to let the whānau know I'm working that's why I'm not there, not sure what the whānau will say if they knew I had gout, whether they say handle it man or don't be weak or something like that. I'm keen too and real keen to help in the whakapapa model got some good ideas for that.*

*(**Fifth and sixth brother**) Well we are the youngest and yeah our tuakana have said everything, what we want to add is that kaupapa on Whakamā we can see how just that simple kupu can paralyse you; stop you from getting the proper help. All those feelings we experience, feel real stink, shamed at what the whānau will say. We not saying that it is Whakamā on its own, we know there are other things that impact, but man can see how Whakamā has its own kaupapa. It's almost like one of the life sources, I tell you if you don't deal to the shame it will eat you up, not literally, but you know what I mean (nod from the researcher).*

Whānau 7 verbatim (GS: 2, WM: 3) – disabled 2 males

Were both brothers, I am 35 and my brother is 25, we have other brothers and sisters but our luck we the only two who has gout. I am the second eldest and our bro is the youngest, our whānau supports are our wife's and our mum.

(Eldest brother)*My dad had gout, his father and some of the brothers aye mum (mum nods). My dad was a hard worker all his life, in the building trade, never heard him complain about anything, he would come home some days in a lot of pain and say to us kids he got hurt at work, he never missed a day even if he was in pain. I was in my late twenties or early thirties when I got this pain, I told my wife about it and she told me to go to the doctors, I said no I will be alright. But the pain kept coming back, I told my mum about it and she asked me some questions and where* *was the pain, and she said to me ooh you poor thing you got your dad's disease. I said what, she said you got gout; you will be alright your dad never complained. So I kept it to myself. That pain was agonising and I kept thinking well by dad put up with it so can I. I take anti-inflammatory from the chemist; don't complain about it, it's just the way it is.*

(Second brother) *yeah that's pretty much the story we were told, dad put up with it so you can, I asked dad one time about his gout, he told me his priority was his whānau, if he stayed home cause of the pain how would he feed the whānau, your whānau are the most important thing in this world, never forget that son, it's just one of those things you and your brother got dealt the same hand as I did, if you let it (gout) take control of you its game over, so son get the anti-inflammatory and look after your whānau. I never forget that, so like my bro, don't complain about it, take your tablets cause that's all you can do.*

(Mum) *when I saw your poster I told my sons to text the number and let's see what this person can do for us, my boys were abit reluctant about texting you, so I told them about their dad. My husband never showed his pain in front of anyone, except me, I felt so aroha for my husband the pain he would endure, the sleepless nights, he really suffered. In those times you really didn't go to the doctors to have a conversation that you are in a lot of pain, well that is our experience anyway, money was tight so my husband would say everything will be alright, he never really talked about his pain, he just would say my dad said the whānau was the most important thing in this world, apart from God, your duty is to your whānau and providing for them. Girl (researcher), you mentioned about Whakamā, my husband was in that state, he was too shamed to ask for help, that korero about whānau, has been passed down through generations all the way too my boys, and you know in this time things have changed its okay to ask for help. So that's why I said to my boys to text you cause they are young and vibrant and clever enough to help my mokopuna that probably will get gout, I don't want my mokopuna to be silenced, Ka pai mum.*

Whānau 8 verbatim (GS: 3, WM: 2) – disabled, 2 males, 1 female

I am the sister of my two brothers, I am the eldest in the whānau, (points to) he's the eldest brother and he's our baby. Let me just say we are all in our fifties and they are my sister-in-laws. It wasn't until late in my life that I found out our dad had gout, that's all I know about that. I was a single mum raising three kids; I think I was in my late thirties when I got gout. It was the meanest pain ever, couldn't do much when I had it, got grumpy a lot, and just handled it. I went to my doctors when I kept *getting it and he told me I had gout, that was about it, told me to take some voltaren, stay off sea-foods, drinking alcohol and it should pass, so that's all I know.*

You asked about whakamā, I always thought of whakamā when you have real bad things in whānau and the shame of it all. I never thought of whakamā with your wellbeing. I guess if I am honest, I probably felt some burden; there were times when I couldn't go to my kid's sports days or events at the school or when they were playing sport cause of the pain. I did feel sorry for my kids, you know, some guilt cause I couldn't be there. I'd try to make it up to them later like take them to the pictures or McDonalds things like that, but I know it didn't replace my absence from these important events. So that burden of not been able to be there for my kids when they had important things they wanted me to come to, still plays on my mind. When I saw your poster I thought why not it might help me understand gout better and maybe be able to deal with it in a better way.

*(**Eldest brother**) Our sister came over to visit and asked our baby brother to come over too, she told us that she had gout, what a shock, we never knew that, I just thought me and the bro got it. She asked us can we come with her to see you about gout because she has had enough, we didn't even have to think about it we said yes, so here we are. The doctor told me ages ago I had gout but I really haven't done anything about it. I too take anti-inflammatory tablets and have just tried to handle it as it comes. Man, the pain I can't tell you the level of pain you go through but too say its 100+ on the pain threshold. I realise pork sets off my gout, so at least I know that much, the only ones I have talked too about gout, is my wife and my youngest brother.*

Just like my sister I never thought of Whakamā with wellbeing but makes sense how just that kupu can stop you from asking for help. I think for me it's the shame and then having to sit with someone to talk about it with. But must admit it has been good to talk about it tonight so yeah, want to learn more about gout and how my pork sets off my gout. I do want to know what is uric acid? My doctor has said to me I have high uric acid levels but what does that mean? So good to talk to you tonight and have some info makes sense, thanks for that, and yeah been keen to help in the whakapapa model too.

*(**Youngest brother)**Well I too have a similar story, like the bro I never knew our sis got gout until she came over to ask us to come and talk to you (researcher) about living with gout. The bro and I would talk about it and kind of swap notes about what tablets work faster. I never considered whether I could do anything about it, you know, stop it from coming or limiting the attacks I get. Like I was saying before, I talked to my bro about gout but not really the pain side of things, I talk to my wife in more detail you know without anyone hearing. I felt ashamed to let my feelings out*

about how bad it is living with gout, my wife said to me after my sister had asked us to come and talk to you (researcher) this would be a good thing. What if other men out there are feeling the same as you about the shame of this disease, gee you could actually help heaps of men. That really hit home for me, so at one level I am here to learn and educate myself better about gout and maybe my story will touch other whānau *and help them get help.*

Whakamā now that's an interesting concept, so if shame is that state of feeling I am experiencing has this stopped me from talking to others to get help? Interesting, maybe, not sure at this point I need to think about this further and I will let you know, cool (researcher acknowledges).

The Findings Post-Whakamā Questionnaire

The same question set were asked both pre and post engagement. The rationale for applying the same questions was to determine whether a paradigm shift of thinking increased their knowledge about gout. On completion of the one-to-one *whānau* interviews the post-whakamā questionnaire was applied, these questions were the same as the pre-questionnaire.

Post Whakamā questionnaire

Question 1 (a) what does whakamā mean to you?

- 30 participants responded to rating 3' good understanding on whakamā' and 20 participants responded to rating 4 'very good understanding on whakamā'.

Question 1 (b) Do you think whakamā has contributed to you getting help from a health professional for your gout?

- Q1 (b) 50 whānau (participants) stated that 'yes, they could see how whakamā contributed or could contribute to them getting help from a health professional for their gout.'

Question 1 (c) Do you think whakamā has contributed to you not getting help from a health professional for gout?

- All 50 participants stated "yes, they could see now how whakamā contributed to them not seeking support,"

Question 2 (a) Do you think whakamā has had an affect on you?

- 35 participants responded to rating 3 "somewhat understanding how whakamā has had an effect on them" and 15 responded to rating 4 "very good understanding how whakamā has had an effect on them."

Question 2 (b) Due to this affect, do you think whakamā has contributed to you getting help from a health professional for gout?

- All 50 participants responded that 'yes, they could see now how whakamā contributed or could contribute to them seeking support for their gout.'

Question 2 (c) Due to this affect, do you think whakamā has contributed to you not getting help from a health professional for gout?

- All 50 participants responded 'yes, they could see now how whakamā contributed to them not seeking support.'

Question 3 (a/b) As a result of how whakamaa has affected you, do you think whakamā has contributed to you getting help from a health professional for gout?

- As a result of how whakamā affected them, all 50 participants responded, 'yes they could see now how whakamā contributed to them seeking or not seeking support from a health professional for gout.'

There was an immense transformation process of thinking that occurred for all *whānau* (participants) as a result of the post-whakamā questionnaire. The shift of thinking in question one gauged the whānau (participants) understanding on whakamā, *whānau* (participants) pre-responses indicated 48 *whānau* had somewhat of an understanding to whakamā and 2 a good understanding, post-response indicated 30 "now have a good understanding and 20 indicating a very good understanding." A connection between whakamā and health appears to have occurred, evidence of this connection is previously noted from whānau (participant) verbatim of their experience of living with gout, "*that kupu we can see how just that simple kupu can paralyse you; stop you from getting the proper help…. All those feelings we experience, feel real stink, shamed at what the whānau will say….we not saying that it is whakamā on its own, we know there are other things that impact, but man can see* *how whakamā has its own kaupapa, it's almost like one of the life sources; I tell you if you don't deal to the shame it will eat you up, not literally, but you know what I mean."*

The questions asking if *whakamā* has contributed to you seeking or not seeking help through a health professional for gout. The paradigm shift through whānau (participants) responses rose from 48 participants indicating they were unsure, to 50 participants indicating yes to both. There was also a slight shift of thinking in whether they thought whakamā had an affect on them, from 48 indicating to "somewhat degree" to 35 still indicating the somewhat and 15 indicating they were affected. From an observational perspective evidence from whānau (participants) verbatim of their experience of living with gout moved from a state of disablement "*shame, burden, anger, keep silenced, don't talk about it*" to a state of enablement, "*it's okay to ask for help, how can we manage our gout, if I understand what gout is all about I can talk to my whānau as well and bring them out of this shame we think gout creates, we want to learn more about gout."* From an observational perspective the transformative process of learning transpired into truly caring for self and others, a process of emancipation that occurred for whānau (participants).

Gout sufferers enabled and managing their gout

There were thirteen gout suffers, twelve male and one female, aged between early thirties through to fifty years and over from and these participants were in Whānau 1, however two were disabled and discussed further in whānau disabled, Whānau 3 and Whānau 4, who accessed support through their doctor and are managing gout effectively. There is a sub-category that emerged from these interviews and will be discussed as to the paradigm shift of being disabled to a position of enablement.

Patterns of disablement

> **Whānau 1***"we don't say the word 'gout' it's a tapu (sacred) word for our whānau it is like a secret code that only we know about, we can read the body signals and the tablet is left in the letter box ...see gout as a burden, a shameful disease, knocks our man-hood... (after 5 years) I believe this was the kupu (referring to Whakamā) that stopped us from talking about it and the years of hiding the shame of this disease kept us in a bubble cause of it." Behavioural patterns: put up with gout, just handled the pain because you're a man"*

> **Whānau 3** *"I just put up with the pain for over 30 years, my wife got gout in her late fifties and I felt so bad to think my wife had got this disease. I felt so burdened that my wife had gout and I felt really guilty because I thought I had given my wife gout ...I can tell you exactly where Whakamā had affected me, was when I*

truly thought I gave my beautiful wife gout." Behavioural patterns: handle it, put up with the pain, and kept silent about it"

Whānau 4 *"never use to talk about gout in our family its one of those things we just sort it out ourselves, the whānau would laugh and it made us worse… they would say the same thing ooh yeah on the piss again cuz… I reckon the shame held me back from talking about it …our father did exactly what we did in the beginning when we got gout, said nothing, handled it, put up with the pain, and felt shamed about having it, (after two years)… we had enough." Behavioural patterns: handle it, put up with it, keep silent, and say nothing.*

The key disablers for these whānau (participants) were the years they kept silent, the shame of the disease and how previous whānau/family treated each other. There was little knowledge about gout and it is clear the passing down of information from whānau to whānau had a significant influence upon their decisions to seek help. The behavioural patterns evident were centred on manhood that shaped how one perceived the disease as a man, "cannot show vulnerability, just handle and put up with the pain, don't say a word, and keep silent." This indicates *whakamā* (inner consciousness, facial/body expressions) as a contributing factor that disabled gout suffers seeking support from a health professional for their gout. It also supports the Māori Action Gout Research Group myths why gout sufferers do not seek support for their gout.

Patterns of enablement

Whānau 1*"I had enough of living like this, it was me that said to my cousin, (after 5 years) hey we need to talk about this… I went to the doctors and spoke to him about it, he gave me some pamphlets and we had abit of a korero about gout and there is a table that can help, I should have done these ages ago, my whānau helped me heaps as well, they are important to me and this also helped me get through."*

Whānau 3 *"when I truly thought I gave my beautiful wife gout, well lucky for me I didn't… it was over twenty years before I realised I didn't, that day the burden was lifted form me, I felt a new person again, like I was purified and given a second chance, this was the day I got help."*

Whānau 4*"just had enough of been in pain, I started talking to my wife about it, we did a little research on line, and got support from my doctor, the most important thing in my mind was our kids, so I thought if we can learn about gout, we*

> *can teach our whānau so they don't have feel shamed about it, I contacted other whānau and we had a hui… when the nephew called us about the gout in the whānau this was a good opportunity to address some of the taake (issues) that we have been silenced by, gout been one of them, as a whānau we have educated ourselves about gout and we manage it well actually, mostly because we have whānau tautoko (support)."*

The apparent shift of thinking from disabled to being enabled for these whānau (participants) appeared to occur from a whānau member taking control of his/her health. The future whānau members with gout no longer have to be silenced by a crippling disease, no longer have to bear the shame on their own and become isolated from *whānau*/family. It was also noted having close *whānau/*family tautoko (support) made a world of difference for the gout sufferer and easier to make the decision to seek advice and guidance from their doctor/health professional.

Gout sufferers disabled and not managing their gout

There were seventeen gout sufferers, fifteen male and two female, aged between mid-twenties through to fifty years and over, these participants were in Whānau 1, Whānau 2, Whānau 5, Whānau 6, Whānau 7 and Whānau 8, who were not managing their gout and had limited access to seek support through their doctor and/or health professional. These participants also have had gout for a long period of time and have "just put up with it" this was evident in the participant's verbatim signposting patterns of disablement.

Patterns of disablement

> **Whānau 1 "***We are not so convinced, its having to take the tablet for the rest of your life, is that a good thing? We haven't moved much for gout, it's a shameful disease, knocks the man-hood if you know what I mean, the burden it creates, having to take time off work, I still ring the whānau for the tab… and use the secret code non-verbal communication*." Behavioural patterns: put up with gout, just handle the pain because you're a man, self-image of manhood, do not show your emotions.

> **Whānau 2***"dad would isolate himself from the whānau; it could be up to a week sometimes before we saw him, even though he was in the next room. He would not let anyone come near him, just mum, it was horrible to know that my dad was in so much pain and there was nothing anyone could do, we'll that's what we thought anyway. When I got gout I was in my early thirties and I did exactly what my dad did to us, I isolated myself too. men folk handled gout, it was a disease that silenced us;*

kept us in a state of Whakamā, I was too embarrassed to say how much gout really hurt, it was not manly like to say it hurt, it was something you kept to yourself… little knowledge about gout, the stereotype of men just handling it; don't show your emotions, the man is the head of the whānau/family. These are just some of the things that those with gout have to manage, it's not easy, and you just get on with it." Behavioural patterns: self perception of manhood not showing your emotions, isolating oneself, just handle it, put up with the pain, and keep silent about it.

Whānau 5 *(husband) "I got gout in my thirties. I talked to a bro at work about the pain I was experiencing and he said I have gout, because he gets it. I asked him what he uses to fix it, he said he takes voltaren and handles it because there's nothing you can do about it. You know when men experience pain, we don't kind of poor our hearts, like women do (whānau laugh) we close our mouths, cause if I was to say hey it hurts, my mate might have mocked me, no way am I gonna look dumb or weak, you know, it was embarrassing, somewhat shameful, my mate handled it so why can't I, and I didn't want the doctor to think I'm weak or something like that. (Wife) I guess there was a little embarrassment in it, but it was more the not knowing that got me, I guess like a burden you know, cause didn't know if you could die from it, that was the biggest worry for me, why didn't I go to the doctors about it? I had more important things to worry about in my whānau with tangi and things like that than to worry about myself, my whānau are important to me so I guess there sickness takes precedence."* Behavioural patterns: handle it, put up with the pain, self-perception of man-hood do not show your emotions and kept silent about it.

Whānau 6 "*I was told I had gout I got really angry, I didn't really know how bad this disease was, I didn't know what it meant to me that I had gout, I thought it must be a whānau curse or something cause gout really cripples you, you can't think properly cause of the pain, you get angry and frustrated cause you laid up in bed, I couldn't even have a sheet over my foot cause it was so painful…. though there's heaps of info out there on gout you have to be a genius to understand what they talking about, even when people that know about gout talk to you it might as well be in Japanese cause I still don't get it … its abit hard talking about the pain, you know people say in today's world it's okay to talk about your feelings and everything, well its abit hard for me, I guess if I was too think of a word or two to say what it's like living with gout? I would say it's terrible, it's crippling, it's shameful… it's not a mamae that you go out and share you know it knocks the manhood, you handle it… I can't play with the kids or join in whānau gatherings cause of it, I told my wife to let* *the whānau know I'm working that's why I'm not there… feeling stink, shamed at what the whānau will say, the comments they might make."*Behavioural patterns: handle it, language barrier, self-perception of man-hood do not show your emotions and put up with the pain.

Whānau 7 "*My dad got gout, his father and some of the brothers, never heard him complain about anything, when I got gout I asked talked to my mum she said I got my dad's disease, I said what? she said you got gout, you will be alright your dad never it, I kept it to myself, I kept thinking well my dad put up with it so can I… dad said his priority was his whānau, if he stayed home cause of the pain how would he feed the whānau, your whānau are the most important thing in this world, never forget that son, it's just one of those things you and your brother got dealt the same hand as I did but if you let it (gout) take control of you its game over… so son get the anti-inflammatory and look after your whānau."* Behavioural patterns: message passed through to the next generation, self-perception of man-hood, your whānau is your priority, handle it, don't complain and isolation."

Whānau 8 *"I think I was in my late thirties when I got gout, it was the meanest pain ever, couldn't do much when I had it, got grumpy a lot, and just handled it, never talked to anyone about it, I probably felt some burden, there were times when I couldn't go to my kids sports days or events at the school or when they were playing sport cause of the pain, I did feel sorry for my kids, you know, some guilt cause I couldn't be there, the burden of not been able to be there for my kids when they had important things they wanted me to come to still plays on my mind ... the doctor told me ages ago I had gout but I really haven't done anything about it ... I think for me it's the shame and then having to sit with someone to talk about it ... I feel shamed to let my feelings out about how bad it is living with gout."* Behavioural patterns: whānau your priority, handle it, don't complain and living with the burden.

The key disablers for these whānau (participants) are very similar to the previous whānau (participants) who are enabled. The common themes evident in the verbatim were the limited information that was passed down from whānau to whānau had a significant influence upon their decision to seek help. These influences were affected through limited knowledge known about gout, myths formulated such as, '*there is nothing you can do about it*,' self-perception of this disease upon man-hood, and how previous whānau/family members addressed this disease.

The behavioural patterns evident again was the self-perception of this disease upon man-hood that had a devastating affect in shaping how the individual's should address this disease. This line of thinking is supported through whānau (participants) verbatim statements that reflects this affect; "*there is nothing you can do about this, cannot show your vulnerability, just handle it, you just put up with the pain, don't say a word that you have gout and keep silent*." This indicates *whakamā* (inner consciousness, facial/body expressions) as a contributing factor that disabled these whānau (participants) seeking support from their doctor and/or health professional about gout. Furthermore, aligns to the Māori Action Gout Research Group myths why gout suffers do not seek support for their gout,

Whakapapa for the Paradigm Analysis

For all thirty gout sufferers links can be found within this framework using *te kore* (abyss), *te po (*voids of darkness) *and te ao marama* (world of light). *Te Kore* (abyss) considered opportunities to identify stages of underdeveloped growth, as a result this was indicated through limited knowledge that was passed down from generation to generation and they did not seek further clarification on it. This further influenced behavioural responses signalling disengagement and isolation for a period of time.

Te Po (voids of darkness) signified emptiness and darkness of the mind, due to limited light and knowledge. It symbolised gout that had been left unattended for a period of time. This was evident for all *whānau* (participants) discovered in patterns of disablement verbatim statements, '*put up with gout, isolated myself, it silenced me, didn't want to look weak, there is nothing you can do about gout, don't complain about the pain, it was a burden*,' these states experienced by *whānau* (participants) was a minimum of five years. This indicates the long period of time they suffered with gout and remained in this state with limited knowledge. As a result, influenced their behavioural responses of further isolation, hiding the fact they have gout, by making excuses for their absences from whānau gatherings/events due to other commitments, beset by feelings of being misunderstood, misjudged and this is turn gout sufferers had a range of experiences such as loss of employment, loss of relationships and isolation.

Te Ao Marama (world of light) the moment of ascension from darkness into light, the gasp or sudden intake of breath referred to as '*Tihei mauri ora'* (breathe of life). There were thirteen whānau (participants) prior to the interviews been undertaken, (whānau 1, whānau 3, whānau 4), that were considered to be in *te ao marama* they were positioned as enabled and managing their gout. While seventeen were seen to be in the disabled and not managing their gout; they are still considered to be in *te ao marama* they chose to engage in this research to learn more about gout, this is evident in whānau 1, whānau 2, whānau 5, whānau 6, whānau 7, and whānau 8, verbatim statements, "*keen to talk further how we can manage our gout, I reckon if I understand what gout is all about I can talk to my whānau, I said to my boys they are young and vibrant and clever enough to help my mokopuna that probably will get gout, I don't want my mokopuna to be silenced.*"

Summary

This chapter explored whakamā (inner consciousness, facial/body expressions) as a guiding principle to unearth myths about gout. There were two specific themes that evidenced whakamā; the stories that were passed down through generations had a devastating effect to the decision-making process for whānau (participants) seeking support for their gout through a GP or health professional. All male participants were influenced by self-perception of man-hood with this disease; the states of feelings held *"shame, burden, handle it, get on with it,"* appeared to suppress their man-hood, limit them seeking understanding for this disease because they did not want to appear 'weak.'

The depth and breadth was examined through pre and post whakamā questionnaires, powerful messages through the interviews emerged. These messages were transmitted through stories, self-perception of manhood and the limited knowledge known about gout, it appeared they were in a 'petrified state,' that dislocated them from engaging in dialogue. This state was further supported in the *whakapapa* (genealogy) paradigm of *Te Kore* (abyss) the realm between non-existence, representing non-engagement, fear of movement, and existence, and the realm of potential. *Te Po* (voids of darkness) signposted the emptiness and darkness of the mind with limited light of knowledge. In this instance the fear of movement of understanding gout and its effect upon one's being. *Te Ao marama* (world of light) articulated and signalled signposts of whakamā patterns of behaviour and states of being, a paradigm shift of thinking to change the fear of movement to the realm of potential to the realm of possibilities.

It was evident that *whakamā* (inner consciousness, facial/body expression) as a guiding principle provided indicators that unearthed myths about gout, unearthed inner consciousness of states of being and unearthed patterns of behaviours. Furthermore, whānau (participants) strongly emphasised in the development of the whakapapa model, whakamā must have a place. The discussions and insights about whakamā (inner consciousness, facial/body expression) they have learnt has contributed to them shifting to a position of enabled in seeking support for their gout.

Chapter seven provides part two of the research and discusses the development of a whakapapa model about gout. It explored the development of a whakapapa model about gout through a Wānanga approach and applied a reflective process to the learning. A whakamā (inner consciousness, facial/body expressions) framework emerged offering further insight in its construct and signposts signalling states that must be considered when working with Māori sufferers of gout. The clinical framework applied explored the process about gout and its pathway through the body and signalled its importance within the whakapapa model. The whakapapa (genealogy) paradigm applied *Te Kore* (abyss), *Te Po* (voids of light) and *Te Ao marama* (world of light) to articulate and signal signposts of gout behaviours, characteristics and states of being. Buck, T.H. (1949) growth model *Te Pu* (root cause), *Te Weu* (rootlets), *Te More* (taproot), *Te Aka* (vine) and Te Tipuranga (growth), provides the growth and development within the *whakapapa* paradigm that connects behaviour and lifestyles requiring consideration for recovery.

Chapter Seven

The Whakapapa Model for Gout

The Wānanga Process

Wānanga (higher place of learning) approach was viewed as the better method to bring whānau (participants) collectively together; this idea is supported by Smith, P (1913) who states:

> "*Māori have always embraced the acquisition of knowledge as a means of maintaining their mana and enhancing their quality of life. This is common sense. Māori society valued knowledge and maintained various institutions for its preservation and its dissemination at different levels. The teaching of essential everyday tasks was a day-to-day activity and individuals learnt through observation and practical experience. Learning took place while tending gardens, gathering seafood, and performing other tasks essential to the welfare of the people.*

The focus of the *Wānanga* (higher place of learning) was in the development of a whakapapa model about gout, ensuring the transmission of knowledge succeeding generations was vital to the survival of Iwi and Hapu. The *Wānanga* (higher place of learning) is still carried out by whānau/family, hapu (sub-tribe) and Iwi (tribe) for this given reason and require of the whānau/family would progress until they mastered each level of the learning process. The whānau (participants) in this research also believe that *Wānanga* (higher place of learning) process has the ability to join *ma-ta-waka* for the common cause and in this instance, to join Māori whānau/family working together to help each other to enable them to seek support for their gout.

There were fifty whānau (participates) both gout suffers and their whānau support who participated in four Wānanga during March through to May 2012. The information gathered from this process was collated and a copy was provided to the eight whānau (participants) groupings that would contribute towards the development of a whakapapa model about gout. The same pattern occurred at the Wānanga and commenced with *karakia* (prayer) as is the normal practice undertaken prior to commencement of a session. The four Wānanga captured the *korero* (discussions) through a tape-recorder and each Wānanga the researcher provided transcripts and was read back, clarified and asked to verify as being correct.

There were eight whānau groupings participating in this research and collectively to conduct four *Wānanga* (higher place of learning) on a marae located in South Auckland. Due to *whānau* (participants) commitments, not all whānau (participants) could join as proposed, the end result two whānau (participants) groupings were made up. In total eight Wānanga was carried out with these two whānau (participants) groupings and were run at different locations within the South Auckland communities, majority was facilitated in the whānau residents. Table 4 below indicates the whānau (participants) groupings that worked together in the *Wānanga* (house of learning) and on completion of the whakapapa model about gout were able to meet on the final date of the noho.

Whānau (participants) Schedule for Wānanga

Whānau Groupings	**Wānanga Dates**	**No Present**	**Wānanga Groupings**	**No. present**	**Dates of Wānanga**
Whānau 1, 2, 7, 8	10-11 March 14-15 April 12, 13 May 9-10 June	20 at each noho	Whānau 3, 4, 5, 6	30 at each noho	10-11 March 14-15 April 12, 13 May 9-10 June

Reflective Process

By definition a good educator are reflective practitioners, they strive for improvement in their practice, they challenge and question oneself, look for new and improved ways of working so that all learners are enabled to make the best possible progress. If one considers their role as an educator we are already well established in this reflective process. Professional development includes being trained to analyse what we do in the course of everyday life of an educator/social worker/researcher and to find the best ways to make a difference for the people. This idea of continuously improving practices Branch, W.T., Parajape, A. (2002) suggests:

> *"Reflection leads to growth of the individual, morally, personally, psychologically, emotionally and cognitively. In order to continue to improve and learn more about effective teaching, one needs to make time and space to think carefully about professional competence across an increasingly broader range of knowledge, skills and expertise."*

This process is connected to the philosophical principles of a Wānanga in transmitting bodies of knowledge to participants to transform learning into practice that is meaningful to them.

This process of Wānanga provides individuals the opportunity to: reflect on their learning, better understand strengths and challenges in their life's, identify and question underlying values and beliefs, acknowledge and challenge possible assumptions on which one may base ideas, feelings and actions, and identify possible areas for improvement. It supports greater self-awareness, which in turn is a first step to positive change, taking time to reflect can help identify approaches that have worked well, and in that way reinforce good lifestyle choices.

Research Themes

There were two central themes that emerged from chapter six part one of this research. The *whānau* (participants) were either enabled or seeking support for their gout or they were disabled from knowing how to seek support. Through the pre-post *whakamā* questionnaire's it was evident that *whakamā* contributed to *whānau* (participants) being enabled or disabled. Furthermore *Whakamā* (inner consciousness, facial/body expression) provided depth and breadth of understanding from a cultural positioning to better make sense for whānau (participants) possible barriers that existed for them. A Wānanga approach was applied and locates a clear link between action, reflection and change within this style of learning. In this process of Wānanga an activity-reflection model using four stages to the cycle of reflection was considered:

- The initial or new experience
- Reflection and observation
- Development of a new concept
- Experimentation

Wānanga One – Whakamā Framework (10-11 March 2012)

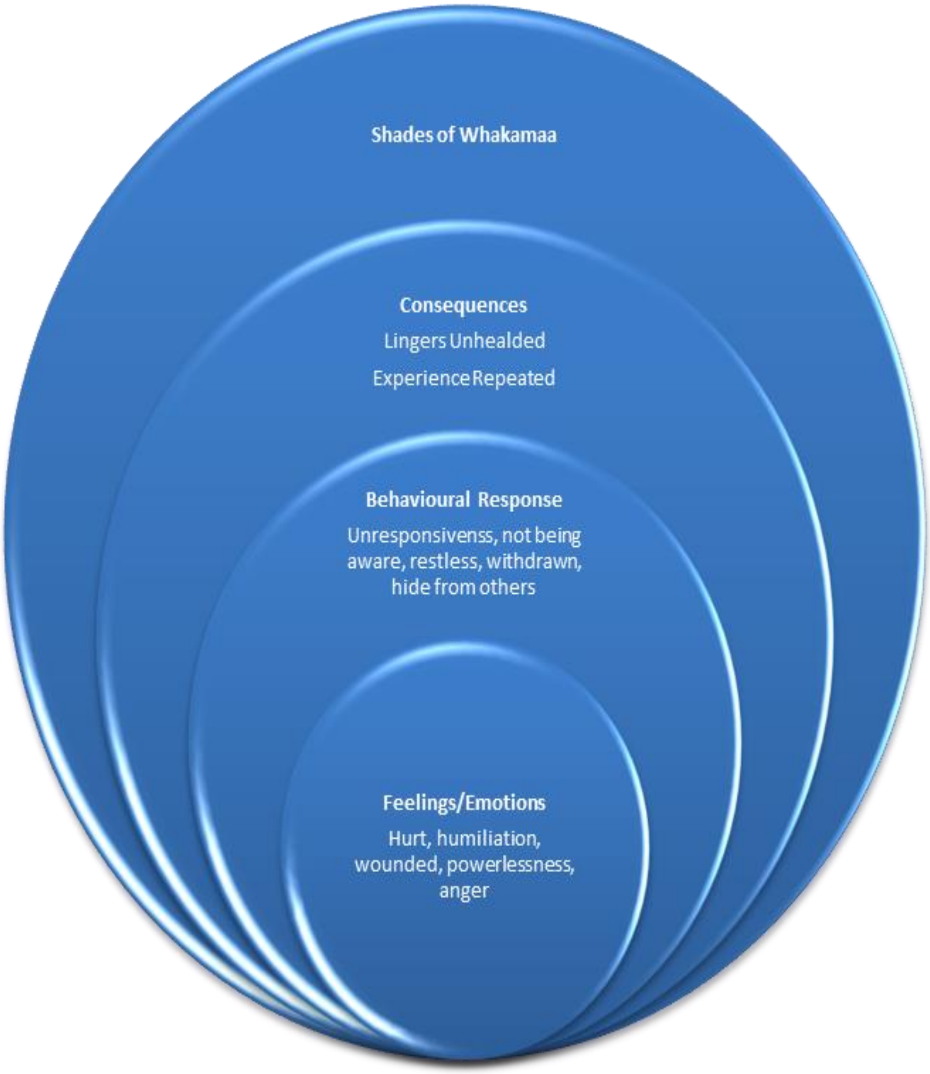
The new experience undertaken in the first week of Wānanga was spent considering how *whakamā* (inner consciousness, facial/body expression) could contribute to the overall whakapapa (genealogy) model about gout. Within the two whānau (participants) groupings, there were two whānau (participants) selected from each group to facilitate the process in gathering information from the whānau (participants). Whānau (participants) were placed in working groups of up to five members and were asked to develop some questions about *Whakamā* (inner consciousness, facial/body expressions) and feedback to the wider whānau groupings. Although there were many questions that came out of each whānau groups, it was collectively agreed by all whānau (participants) three questions that should be considered and they were:

1) What are the feelings/emotions you experienced when you found out you had gout?
2) How did these feelings/emotions change your nature/behaviour?
3) How did whakamā effect your whole being: *taha hinengaro* (thinking), *taha wairua* (being/spirit), *taha tinana* (body), *taha whānau* (the whānau/family)*?*

This process is considered as reflection in action the ability for the whānau (participants) to think through what they are doing while they are doing it and progressing towards a common goal. This is supported by Schon, D. (1983) stating, "*Through the ability to think on your feet, and apply previous experience to new situations, requires the capability of reflection-in-action."* The environment was also an integral part of learning for the transmission of learning to flow freely, an environment that was conducive to the wellbeing of all participants to progress from one level to a higher level of learning.

Day two, the process of reflection occurred; whānau (participants) worked alongside the researcher to piece together the information that represented their contribution to *whakamā* (inner consciousness, facial/body expression). The role of the researcher was to facilitate the process using a mind-map and whānau (participants) contributed to the development, as a result, a framework emerged.

Emerging Whakamā Framework



Whānau (participants) further added questions that would assist them in talking to their whānau (participants) about how *whakamā* can contribute to them seeking or not seeking help for gout but noted this framework as a possible pathway for whānau/family taake/issues.

1. Define the space of Whakamā?
2. Define/explain/example the states of feelings/emotions experienced from the gout sufferer and their whānau/family
3. Define/explain/example the behavioural responses as a result of feelings/emotions?
4. Define/explain/example the consequences of not addressing gout?
5. Define/explain/example the shades of Whakamā?

This further supports whānau (participants) progression through states of reflection, the ability to reflect on learning and to engage in a process of continuous learning. The next process the researcher and the selected whānau member presented the whakamā framework and offered the depth and breadth of whakamā illustrated through whānau (participants) verbatim. It was further acknowledged this part of the whakapapa model about gout brought forward further pathways to unearth such as:

1) **What are the barriers to whānau (participants) seeking support for their gout from health professionals?**

(a) Inadequate access to culturally safe and appropriate health care for whānau/family for example, feelings of Whakamā (inner consciousness, facial/body expression),
(b) Lack of dissemination of information about gout, the language used to explain was not in a language understood from the communities and the societal pressure of being male having gout.

2) **What can be done to promote positive decision -making processes?**
   (a) Must involve whānau/family,
   (b) Information giving and more advertising,
   (c) Doctor/patient communication and
   (d) Consideration of other cultural issues

To provide appropriate services for Māori, there needs to be Māori perspectives within health care delivery systems and cultural safety frameworks accepted as equal to that of medical model. To achieve this is through more Māori health professionals and secondly, through further education of non-Māori health professionals. These two themes are supported from Willams, P et.al (2003:1) states:

> *"Cultural safety education challenges health professionals to understand and reflect on their own culture, attitudes, and knowledge of power relationships and colonisation/marginalisation.*

The whānau (participants) feel that it offers a starting point for discussion when engaging with Māori about gout and improves willingness to seek treatment for gout problems, as well as other health issues. Whānau support indicated how vital it was for them to be involved in the discussions in relation to their partner's perceptions of health and whakamā (inner consciousness, facial/body expression) for them was the starting point. The whānau support noted "for many whānau/family they cared more for their families' health than their own and the thought of burdening whānau by their illness was too much to ask."

Whakamā (inner consciousness, facial/body expression) offers whānau/family the opportunity to talk about those states of being, and see how it has contributed to keeping one silenced or ashamed to speak out. The next process was for the researcher to transcribe all the information, including the emerging whakamā framework and distribute among the whānau (participants) in preparation for Wānanga two. This is considered in the reflection model as the development of a new concept, through the process of Wānanga, whānau (participants) brought through their own 'knowing' or experience of whakamā (inner consciousness, facial/body expression). This allowed the depth of whakamā (inner consciousness, facial/body expression) to be revealed further and assisted in carrying out the goals and the best possible pathway to place *whakamā* (inner consciousness, facial/body expression). This form of learning is supported by Schon, D. (1983) who states:

> *"The idea of tacit knowledge refers to the kinds of knowledge we can only reveal in the way carrying out tasks and how we approach the problems, "The knowing is in the action. It is revealed by the skilful execution of the performance – we are characteristically unable to make it verbally explicit." This tacit knowledge is derived from research, and also from the practitioner's own reflections and experience."*

The researcher visited the whānau (participants) groupings for further discussion about the information that was disseminated and discussions on further insights and understanding about *whakamā* (inner consciousness, facial/body expression). These sessions were transcribed and placed into whānau (participants) verbatim illustrating further, whakamā as a guiding principle to unearth myths within whānau/family. Several themes emerged, as a result and were added in the development of whakamā (inner consciousness, facial/body expression). The additional information developed further the construct of whakamā (inner consciousness, facial/body expression).

Application of Whakamā framework

The signposts to shades of whakamā are contextualised from the perspective of whānau (participants) and assisted in identifying patterns.

Whakamā Self-Assessment

1. Have you heard stories about gout that you were not sure were right?
2. Have you been put in a position that you felt uneasy about talking about gout?
3. Have you done something out of character because of your gout?
4. Do you have feelings that you cannot explain why, when people ask you about gout?

If you have answered yes to all or most of the above, you may have experienced *Whakamā* (inner consciousness, facial/body expression).

Description of Whakamā

It is a word that stands for a concept that Māori use in the process of organising and talking about their experience of being human. It is a way of thinking about interpersonal relations, which is different from that expressed in and reinforced by the English language. It contains states of feelings of being shy, embarrassed, ashamed, angry, guilt, blame and feeling burdened. Being challenged to do something you don't want to do, maybe afraid of been thought of as a show off. He ahua Whakamā, (a Whakamā appearance), something is seen. Māori use the word in connection with a particular state of mind with nga whakaaro Whakamā, Whakamā feelings in the sense of awareness. Whakamā behaviour is made up of outward and visible signs and is directly observable. Whakamā feelings are inward and invisible; access to them is gained only by listening to what Māori have to say about them.

Development of Whakamā

Can result as a response to a sensitive issue, if whānau/family makes fun or jokes about their gout, through this process depending on the action/s or responses is this liable to cause Whakamā (inner consciousness, facial/body expression)? If there is limited support for the individual or group involved is this Whakamā (inner consciousness, facial/body expression) they may be experiencing?

Variations of Whakamā

Whakamā is made up of inward states of feelings/emotions, and outward states indicated through behaviour, depending on the state the individual or group is experience depends on the level of intensity of the experience and the duration of time an individual or group remains in that state of being. If the state of Whakamā is minor, has little impact for the individual or group, is secure within oneself and support around them, then recovery is quick with little support from others. If Whakamā experience was more severe it became more intense, lasted longer, individuals and/or groups require recognition and support from others. This process of *Whakamā* (inner consciousness, facial/body expression) can linger unhealed, the experience repeated and can become ingrained.

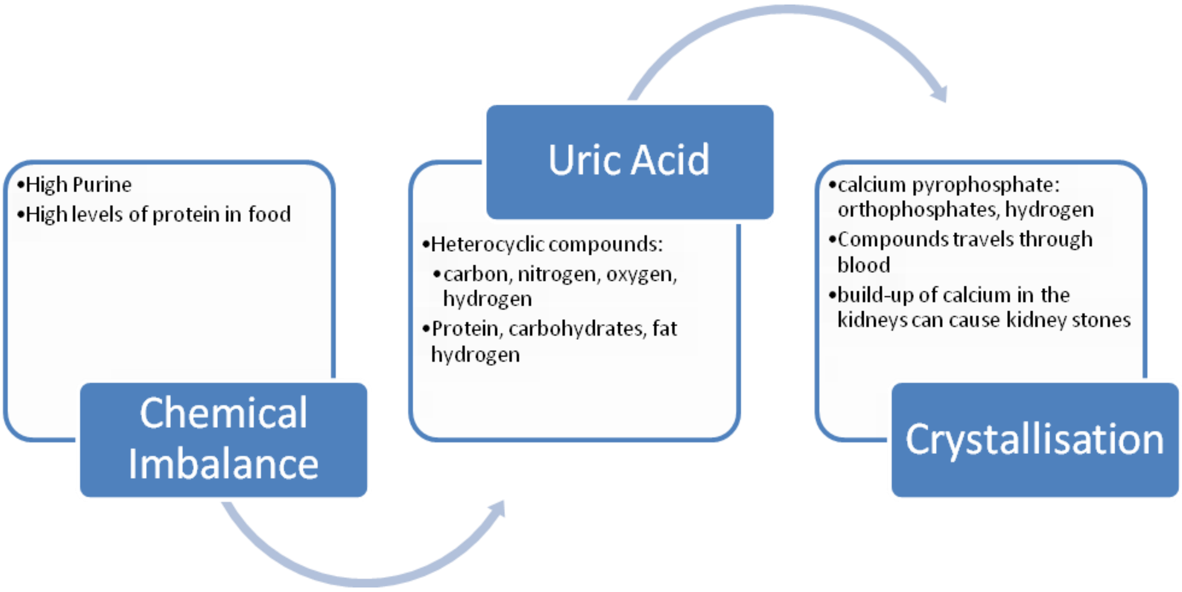
Whānau Reflection

Whānau (participants) verbatim stating "*these questions make sense even more since we have been talking, I think they are the right questions to ask whānau, the question about the stories should definitely get straight to those myths among our whānau about gout, the feelings question is really important to ask especially for our Māori men it will help them release the burden and silence as it has done for us, and it gets you thinking about those states, it's good to note the development of whakamā because most whānau would not understand how whakamā got to that extent in the first place, the variations provided added fuel as to speak, really brings home the importance of how whakamā actually contributes to been unwell, not only for gout but health in general, this would be a good model for health professionals to see if they themselves are in a state of whakamā and do they actually bring whakamā on to others? Why I say that is my experience of the health sector like the hospital, and how I felt bad about being in hospital for my gout, some of those staff assumed things and laughed about it, if they were to see this model would they be still assuming or laughing about it, I think not?*"

Wānanga Two – Clinical/Whakapapa Positioning (14-15 April 2012)

This section of the wānanga took some time to work through as the clinical language was difficult to comprehend; it was decided to use pictures (diagram two) and make the link to whakapapa language. The first process was for the whānau (participants) to learn the clinical pathway on gout and its whānau groupings known as compounds. The diagram signifies a clinical pathway on gout.

Clinical pathway on Gout



The above identifies groups of information in sequential steps. At each step it emphasises the interaction or relationships of compounds relating to the pathway of gout. These relationships signify the whānau/family connections and its impact within the body. The starting point is the chemical imbalance, food related sources that are high in purine/protein levels, once consumed it connects with uric acid forming heterocyclic compounds because uric acid is attracted to the high purine/protein levels. The high purine/protein levels travel with uric acid compounds through the bloodstream and take its normal pathway down to the kidneys. The kidney in turn excretes the uric acid and high levels of purine/protein into a converted soluble form which is salt called urate. Unfortunately this does not always occur, the result is the kidney is working hard to excrete uric acid, purine/protein but also contends with calcium pyrophosphate. The kidney starts excreting but forms stones these are known as kidney stones. The travel of these build up is called crystallisation and crystallisation deposits the build-up of calcium, uric acid and purine into the joints and a gout attack occurs.

The whānau (participants) again went into learning groups to understanding the pathway of gout, whilst compounds where difficulty to comprehend, an amazing transformation of learning occurred. Through observation, the learning to retain, understanding and place the compounds in its sequential order was achieved through the composition of a waiata (contemporary song). Not only does this method of learning align to the reflective-action-model in developing a new concept but also the style of Wānanga. In contemporary Wānanga according to Edwards, S. (2009:259) states:

> *"It provides spaces for the development of thought and activity in the Māori worldview. Wānanga allows for ancestral systems to examine, preserve and transmit knowledge. The ascent of Tawhaki (stories of the Tainui people) in the upper most realms provided the rationale, protocols, and principles upon which the whare Wānanga was to be conducted and determined the subject matter."*

The composition of the waiata (contemporary song) is called Pathway of Mr Gout, sung to the tune of "body connections"

> ***"**Chemical imbalance is connected to high purine, purine is high protein, and high protein is found in lots of food such as kai we all like to eat like kaimoana.*
>
> *Well the next thing that happens is uric acid is on the way bringing the whānau carbon, nitrogen, oxygen and hydrogen, they connect to high protein, carbohydrates and fat hydrogen's which arrived through the source of our food. The unfortunate thing if we have high uric acid the whānau kidney can't process all this protein, so it sends it back into the wider parts of our body.*
>
> *The whānau crystallisation comes calling carrying high levels of calcium and poor whānau kidney is working overtime, whānau kidney can't keep up with the demand and starts to deposit little stone these are known as kidney stones. Out of the kidney comes a rush of calcium, high uric acids and jumps a ride on the pahi toto. Pahi takes a journey through the narrow passages and starts dropping off these whānau, before you even know it the whānau have built a wall causing the passage of toto to be blocked forever more. Next thing you know whānau crystallisation has formed creating barriers and putting up protection so no other whānau can enter within.*
>
> *The final stage the karanga goes out and before you even know gout attack has entered."*

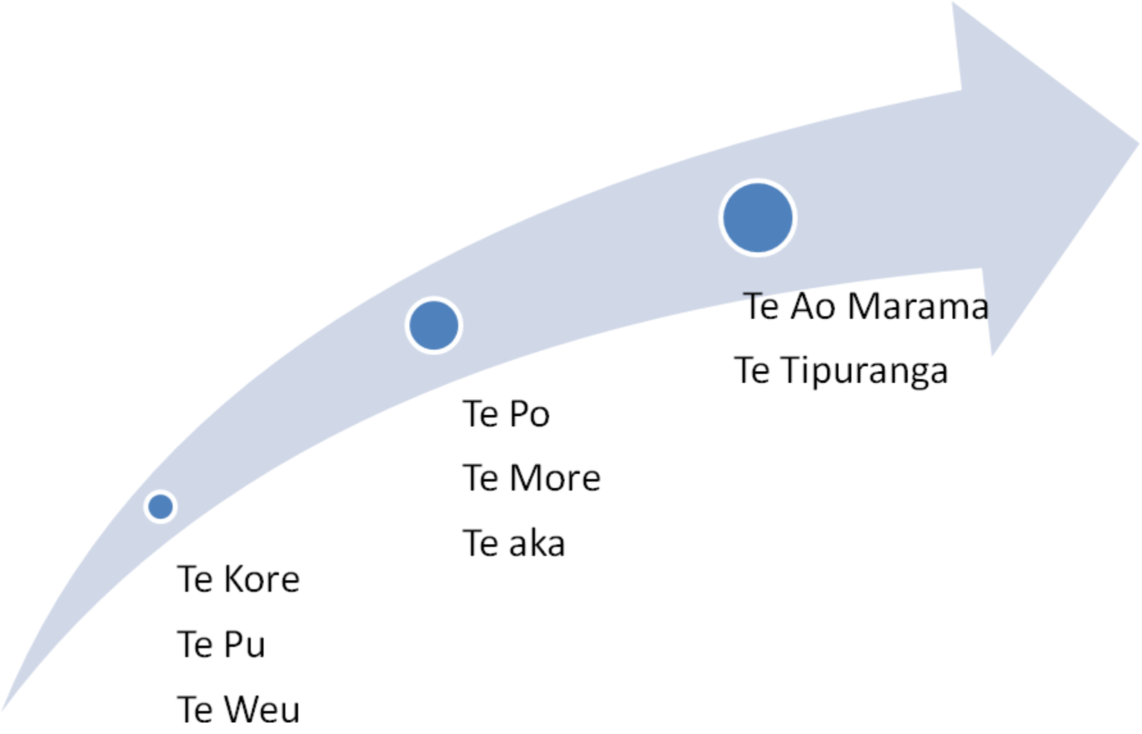
Whānau Reflection

As with the previous Wānanga, the researcher visited the whānau (participants) groupings for further discussion about the information that has been disseminated among them thus far. These sessions were transcribed and placed into whānau (participants) verbatim stating, "*what an amazing journey, the oho (awakening) is happening, I am starting to connect whakamā with my gout, and those compounds in gout, the waiata has helped me retain them, I may not understand fully yet those compounds but definitely known who they are now. This is great learning, this is how our old people use to learn, what an awesome way to learn about oneself but also the ailments that impact upon not only me but the whānau. I can teach that tune about Connections of Mr Gout to the whānau I know who has gout, whānau love singing and for me it helps me remember, so what a great way to learn and have fun at the same time, who would of thought I would enjoy learning about Gout, I can even say*

Gout without feeling 'maa'. Looking forward to the next Wānanga, lots of learning has happened and more importantly I feel so invigorated, like a new leaf of life has come over me."

Wānanga Three Whakapapa/Human Growth Positioning (12-13 May 2012)

Whakapapa/Human Growth



The above illustrates the connections of the whakapapa paradigm and Māori human growth model from the perspective of whānau (participants). Whilst it appears the placing of Te Kore aligns with Te Pu and Te More it should be noted that it is a process of continuous learning and each layer provides pathways of recovery and discovery, each sequence offers signposts and consideration as an individual or whānau grouping travels through the process where potential, possibility and opportunities are endless. It signifies dimensions that merge together showing an overlapping of interconnected relationships. It demonstrates *whakapapa* (genealogy) positioning in an epistemological fabric as a theory that underpins numerous processes for the practice of a collective ideology. This is evident in the process undertaken thus far in Wānanga, whānau (participants) have drawn from experience, their knowing, and learnt from others from their position of whānau/family. Their position has also drawn from bodies of knowledge located in Māori worldview, such as Wānanga, ritual of encounters:

karakia, whakatau, whānaungatanga (interrelationships) and the concept of koha (reciprocal process). Paki, V.A. (2007) further elaborates on the position of whakapapa by stating:

> *"The practice of relationships is the discourse for interconnectivity within whakapapa and the significance of this is seen in the active process of relationships as the means to a continued existence of balance and harmony. Whakapapa forms a view of the world and reality for Māori not merely as a complex system but as a natural progression of existence*

Whakapapa implies that education is a relationship with life and not for one particular purpose or with one particular entity. The attainment of knowledge is the progression to understanding the relationships with others. Paki, V. A, asserts

> *"If connectivity with life is of a holistic nature revolving within an organic system, then the argument here is that knowledge of a pedagogical paradigm serves the purpose of retaining and enhancing the intrinsic nature of the mind and spirit of transcended entities as the source of essence for one's being."*[18]

Te Kore/Te Pu/Te Weu/ Positioning

Knowledge that was passed down from generation to generation, reflecting states of shame, embarrassment and hurt, responses were, disengagement and isolation for a period of time. Still within Te Kore is the realm of potential. *Te Pu* (root cause), individuals comprehend that their inappropriate behaviour has a root cause. Adjustments in personal behaviour and lifestyle can be considered as necessary for recovery. Process of adjustments or behaviour is contingent on redressing negative influences. *Te Weu* is the rootlets or the offshoots from *Te Pu* (root cause) that come off the main root. This is the main root of side issues that are related and intertwined to the root cause of behavioural influences that hinder or slow the process of change and constructive growth. The real causes of behavioural problems are not identified at an earlier stage compromising the journey it requires individuals to utilise their learnt skills in overcoming the stage of *Te Weu* (rootlets).

Te Po/Te More/Te Aka Positioning

Symbolised gout as being left unattended for a period of time, minimum 5 years they suffered with gout, maintained limited knowledge. States of emotions, misunderstood, misjudged, deep shame, deep sadness, deep anger and deep hurt, responses, further isolation, hiding the fact they have gout, making excuses for their absences from whānau gatherings/events. Consequences have resulted in, loss of employment, loss of relationships, loss of whānau connections. *Te More* is the taproot or the main arterial root that causes

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[18] Ibid: 17-24.

growth. The root that can cause a diversion in growth, nurturing and care one is able to add to the quality of life. *Te Aka* the vine represents an internal process that is associated with living or the state of being alive, care and protection given to the taproot and rootlets determines the quality of the vine, the physical evidence of ancestry is symbolised by the roots and thereby affirms one's identity, this evolvement we are taught fundamental principles that give enhancement to our character, cultural identity, process of growth is activated it can give rise to the individual's character, responsibility to take ownership of these, and in turn bring about a state of liveliness.

Te Ao Marama/Te Tipuranga Positioning

> "*keen to talk further how we can manage our gout, I reckon if I understand what gout is all about I can talk to my whānau, I said to my boys they are young and vibrant and clever enough to help my mokopuna that probably will get gout, I don't want my mokopuna to be silenced."*

Te Tipuranga symbolises growth, learning and survival that is dependent on the environmental elements providing and producing nutrients for long-term survival. It is important that access to the elements of nature that provides the basis for further development, and supports in the shaping of ethical behaviour. These are the relationships between people; between people and the physical world; between people and the atua (spiritual entities).

Wānanga Four Whakapapa Model about Gout (9th – 10th June 2012)

The final Wānanga all whānau (participants) attended and worked collectively together drawing from frameworks that emerged from diagram one, emerging whakamā (inner consciousness, facial/body expressions) framework, diagram two, clinical pathway on gout and diagram three, whakapapa/human growth. The framework that whānau (participants) worked from is illustrated in the diagram four below.

Whakapapa Model about Gout

Whakamā
(inner consciousness, facial/body expression)

Kai/food and drink high in purine (protein)
.

Uric Acid

Carbon,

nitrogen,

Oxygen,

Hydrogen.

Uric Acid travels through the blood to the kidneys Build-up of calcium can cause

Crystallisation Calcium Pyrophosphate

Te Kore

Te Pu
(rootcause)

Te Weu
(rootlets)

Te Po

Te More
(Taproot)

Te Aka
(The vine)

Te Tipuranga
(growth)

The above shows interconnected relationships between the clinical processes, whakapapa paradigm and human growth framework. The clinical process begins with the whānau high purine; protein, carbohydrates and fat, connected in this relationship is *Te Kore* (abyss) limited understand of changes occurring for the individual, no connection with gout and its devastating effects. The signposts of gout behavioural responses can be tracked through *Te Pu* (root cause) and *Te Weu* (rootlets) side issues that are related and intertwined to the root cause of behavioural influences that hinder or slow the process of change and constructive growth. The next interconnected relationships are the whānau uric acid; carbon, nitrogen, oxygen and hydrogen continuing their relationship with Te Kore (abyss), Te Pu (root cause) and Te Weu (rootlets).

These relationships invite the whānau crystallisation; calcium pyrophosphate that travels through whānau toto and reaches whānau kidney, this creates tension among these whānau and connects to *Te Po* (voids of darkness) and *Te More* (taproot) that causes a diversion in growth and *Te Aka* (vine) causes growth. As a result of the tension among whānau, whānau kidney requests the whānau to leave but sometimes because of the tension of all the relationships in one space invites another whānau known as kidney stones. The whānau crystallisation leaves the space of the whānau kidney, continues their journey with whānau toto and drops whānau members at each point in the turn known as the Joints rohe (area). The final relationship that occurs is the whānau gout attack, which has a close relationship with Te Ao Marama (world of light) and Te Tipuranga (growth). This framework has been developed into a six-week programme for participants to deliver the *whakapapa* (genealogy) model about gout.

Summary

This chapter explored the development of a *whakapapa* (genealogy) model about gout through a wānanga approach and applied a reflective process to the learning. This process of wānanga and reflective process provided *whānau* (participants) the potential to develop frameworks that would contribute to the overall *whakapapa* (genealogy) model about gout. The first *wānanga*, a *whakamā* (inner consciousness, facial/body expressions) framework emerged offering further insight in its construct and signposts signalling states that must be considered when working with Māori sufferers of gout. This framework provided experiences from the *whānau* (participants) that signalled states of feeling/emotions, behavioural responses, consequences that connected to shades of *whakamā* (inner consciousness, facial/body expression). Furthermore, selected questions relating to *whakamā* (innerconsciousness, facial/body expression) were considered and contributed to the shape and design the pathway of *whakamā* (innerconsciousness, facial/body expression) will undertake. The development phases of this process are captured in Raelin, J. (2002) stating:

> *"Reflection is an active process of witnessing one's own experience in order to take a closer look at it, sometimes to direct attention to it briefly, but often to explore it in greater depth."*

The second *wānanga* was to explore the clinical process about gout, its pathway through the body and signalled its importance within the *whakapapa* (genealogy) model. Whilst this section of the *wānanga* was a challenge through learning of new knowledge, understanding and contextualising its processes, an amazing transformation occurred for *whānau* (participants). They drew from their own 'knowing' and their own experiences and transformed the challenge into a space for potential learning and growth. From observation, the *wānanga* environment provided the transmission of bodies of knowledge to flow freely, their engagement with others in the process of whānaungatanga (interrelationships) and illustrated this learning from a Māori worldview position. The talents of whānau (participants) transposed a challenge and placed the challenge into an area of familiarity and that was waiata (contemporary song). This style of learning can be located in a Māori worldview and as noted previously, Grey, G. (1953) supports this notion, he asserted that a major rationale for his collecting the songs and stories was they from the bedrock and knowledge base for Māori.

The third *wānanga,* the emerging of another framework took shape and that was the *whakapapa* (genealogy) paradigm of *Te Kore* (abyss), *Te Po* (voids of light) and T*e Ao Marama* (world of light). This framework articulated and signalled signposts of gout behaviours, characteristics and states of being and its connections with Buck, T.H. (1949) growth model, *Te Pu* (root cause), *Te Weu* (rootlets), *Te More* (taproot), *Te Aka* (vine) and *Te Tipuranga* (growth), that connects behaviour and lifestyles requiring consideration for recovery. It signified dimensions that merge together showing an overlapping of interconnected relationships. The final *wānanga* offers a *whakapapa* (genealogy) model about gout and has been further developed into a six-week programme for gout sufferers.

The significance of developing a *whakapapa* (genealogy) framework has become a fundamental aspect of the way Māori think about and come to know the world (King, M.1981). *Whakapapa* (genealogy) is acknowledged as a way of thinking, a way of storing knowledge and a way of debating knowledge (Smith, L.T.1999). This process *whānau* (participants) positioned *whakapapa* (genealogy) as a means and way to acquire new knowledge and more significantly applying the *whakapapa* (genealogy) principles with a medical model. This framework addressed many levels for gout sufferers one in particular is the presentation of health literacy about gout.

This framework has the ability to assist gout sufferers and their *whānau* (participants) comprehend the complex issues they face in a language that they understand. It provided key messages most relevant to their needs and culturally addressed areas that would not be considered in normal health literacy, such as addressing whakamā as a guiding principle to unearth myths about gout in whānau, alignment of whakapapa and the clinical process about gout.

In a recent review of health education resources for gout medication summary to the Ministry of Health June (2012:3) states "good health literacy also includes a person having good knowledge of how the human body works, as well as knowledge of specific health conditions, a strong relationship between a person's health literacy and their health status." This framework is shaped to accommodate such learning and more importantly transforming that learning into helping whānau with gout, this line of thinking is further supported by the Ministry of Health stating:

> *"Resources and health literacy need to be written or scripted using language and concepts that work for the target audience. Making a resource understandable is not about 'dumbing down' or reducing information; it is about health professionals being more responsive to the needs of their patients and taking a patient and whānau-centred approach to all forms of information. It is about giving people the information they need, when they need it, in a form that makes sense to them. Once people have acquired the most important concepts and knowledge, then new information can be added to develop a person's understanding of their condition and treatment"*[19]

This statement aligns and connects to the development of a *whakapapa* (genealogy) model about gout that ensured *whānau* (participants) could easily understand the programme as they were the main authors of this model, they contributed to the development of frameworks that made sense from their worldview, demonstrating ways of having conversations with whānau/family and access to health professionals, having the ability to recognise signposts for themselves.

At every level of examination *wānanga* and reflective process occurred. The central focal point and power of transformative learning was a fundamental change in perspective that transformed the way *whānau* (participants) understood and interacted with each other. This was evidenced through the development of frameworks that would contribute to the overall framework. Through this process *whānau* (participants) were questioning their beliefs, values and assumptions relating to gout and discovered new perspectives and strategies to help not only them but their extended whānau/family. This process aligns to the principles of *wānanga* and reflective process the act of reflection as indicated by Jasper, M. (2003) who states:

> *"the act of reflection, promotes the development of autonomy, engaging in Reflective Practice is associated with the improvement of the quality of care, stimulating personal and professional growth and closing the gap between theory and practice."*

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[19] Ibid: 4

The *whakapapa* (genealogy) model about gout from the perspective of *whānau* (participants) and the researcher is a model that can be transformed into another context of health such as diabetes and requires whānau (participants) willing to participate to develop whakapapa model about diabetes.

Chapter eight reviews and reflects upon the positioning of this research and offers key points presented throughout this thesis.

Chapter Eight

Conclusion

Research Findings

The purpose of this research was to focus on the examination of a dual paradigm consisting of Māori and Western bodies of knowledge. By examining the implementation of a *whakapapa* (genealogy) based model as a means to measure a paradigm shift from a medical model perspective of treating gout symptoms to *Te Ao Māori* (Māori worldview) thinking on the disease. The tools of analysis applied to measure the paradigm shift was through a pre-*whakamā* questionnaire, (Table 2) and a post *whakamā* questionnaire, (Table 3). This assisted in understanding *whakamā* (inner consciousness, facial/body expression) as a guiding principle that unearthed the myths about gout among the *whānau* (participants) in this research. This analysis was detailed through the one-to-one interviews of fifty *whānau* (participants), thirty of whom were sufferers of gout and twenty were *whānau* support.

The research explored a clinical process about gout, its clinical intervention and contra indicators. It also developed a *Te Ao Māori* (Māori worldview) cultural framework model using whakapapa paradigm – Te Kore (abyss), Te Po (voids of darkness) and Te Ao Marama (world of light) this framework offered signposts of behaviour and characteristics of gout sufferers. Additionally, a Māori human development model was integrated into the *whakapapa* (genealogy) paradigm, consisting of *Te Pu* (root cause), *Te Weu* (rootlets), *Te More* (taproot), *Te Aka* (vine) and *Te Tipuranga* (growth) and signaled the core of the behaviour and characteristic. These frameworks assisted in addressing a perceived lack of understanding about gout to *whānau* (participants) empowered through the knowledge gained by this research. As a result a *whakapapa* (genealogy) model on gout was developed.

As indicated, this thesis was not an attempt towards a cure but rather to provide a better understanding of managing gout through *Te Ao Māori* (Māori worldview) knowledge, reasoning and rationale. *Whakamā* (inner consciousness, facial/body expression) was applied to unearth the stories about gout among *whānau* (participants) and two themes emerged; there were thirteen *whānau* (participants) who was enabled and seeking support from their General Practitioner and/or health professional prior to the research occurring, there were seventeen *whānau* (participants) who was disabled and not seeking support from their General Practitioner and/or health professional for their gout. What was evident, the paradigm shift of thinking from a medical model perspective of treating gout symptoms to *Te Ao Māori* (Māori worldview) thinking on the disease was an amazing transformation for *whānau* (participants). This is congruent in the application of Māori bodies of knowledge, that were specific to this cultural grouping, driven by cultural frameworks and methodologies and framed by philosophical underpinnings, *whānau* (participants) responded effectively with a dual paradigm than just a medical model on its own. This is further supported from the report to the Ministry of Health (2012:18) about gout, stated in their recommendations:

> *"Ensure resource developers work with the target audience, developers need to ask the audience what they want from the resources, (recommendation 5). Produce culturally appropriate resources, developers require language and cultural knowledge and understanding rather than simply providing direct translation of English resources, (recommendation 7). Prioritise messages about managing gout; people who need treatment and people who can prevent gout attacks. People need to relate to the pictures and information if they are to believe it is relevant to them (recommendation 11)."*

In total thirteen recommendations were produced in a report to the Ministry Of Health (2012). Of interest the selected recommendations noted above speaks to and supports the position of this thesis. The *whakapapa* (genealogy) model about gout was developed by the *whānau* (participants), their experience, their knowing and was produced from the perspective of Māori gout sufferers and their *whānau*, aligns to recommendation 5. The development of *whakamā*, clinical process about gout, *whakapapa* (genealogy) paradigm/Māori human growth was created from *whānau* (participants), their language, and their knowing and lived experiences that contributed to the overall model, was achieved and aligns to recommendation 7. The key messages was drawn from the *whakamā* (inner consciousness, facial/body expression) framework that either enabled or disabled whānau (participants) from seeking support for their gout. An example of messages that disabled all whānau (participants) for a long period of time were powerful messages passed through *whānau* to *whānau*: "just handle it, self-perception of manhood due to the excruciating pain, burden," aligns to recommendation 11.

The questions pertaining to this research was based on the gaps provided through the literature review and proposed the following positions:

1. How would a paradigm shift from medical model framework of thinking to a Te Ao Māori framework of thinking improve Māori health?
2. How would the dissemination of a Te Ao Māori framework of thinking influence Māori communities' engaging better with health services?
3. How would a cultural model, its interventions and indicators for gout support the medical community and best practice?

To assist in addressing these questions, Counties Manukau a Māori Action Group identified five myths that they believe may be undermining best practice by the medical community, patients and their whānau, and perpetuating under-treatment of gout. From the five identified myths, three of these myths were applied and offered further depth of analysis, they were:

3. People who have gout bring it on themselves by drinking too much and eating the wrong food;
4. Gout is a ‘normal part of life and you just put up with it; and
5. Medications for Gout should be taken for acute attacks only.

Whakamā in chapter six critically analysed ‘the lack of understanding about gout among Māori through the one to one interviews; myth 4, was definitely a reality for whānau (participants) in this research that keep them from moving forward, myth 5, whānau (participants) shared their medication when a gout attack occurred, they had limited understanding about the disease gout and confirmed they only used medication when a gout attack happened.

Chapter two examined the disparities in health between Māori and non-Māori that have been evident for all of the colonial history of New Zealand. Although there have been significant improvements in the past 172 years, recent evidence indicates that the overall gap in life expectancy between these groups is widening rather than narrowing. (Ellison-Loschmann, L., Pearce, N. 1996). These differences are a complex mix of factors associated with socioeconomic and lifestyle characteristics, discrimination, and access to health care. Māori-led programs designed to improve health care access are taking a two-fold approach that supports both the development of Māori provider services and the enhancement of mainstream services through provision of culturally safe care. The new initiatives are a result through evidence indicating poorer health status of the indigenous people of New Zealand and their clear demand for improved health services. Māori provider organisations and cultural safety education are examples of initiatives that have emerged not in isolation but, rather, within a context of macro-level government policies that have been shown to either promote or greatly hinder the health status of indigenous peoples (Ramsden I, 2002, Papps E, Ramsden I, 1996, Lurie, N.2004).

There were key findings that supported the basis of this thesis, the debate of inequalities between Māori and non-Māori were evidenced through colonisation that was based on “dehumanising indigenous peoples” (Churchill, W. 2006). It also illustrated the impacts of colonisation for Māori that detailed the phenomenon of colonised peoples in different parts of the world who shares common psychological disorders, “The mental health problems of Māori, manifest in destructive social behaviours can be observed in other colonised peoples who also identify the colonial experience as the root cause," as a result of colonisation (McNeill, H. 2005). The missionaries were seen as the party to cultural invasion and according to Walker, R. (cited in Selby, R.1999) "*had two pronged goals; one was to convert Māori to Christianity and the other was to transform Māori from perceived barbarism to civilised life*." When considering the connections of colonisation and how Māori feature high in negative statistical data today, McNeill, H. (2005) quote offers a good correlation between psychological disorders and its manifestation today. This research with the use of *whakamā* (inner consciousness, facial/body expression) unearthed the surface of this manifestation, through one disease known as gout. The question here is, can *whakamā* (inner consciousness, facial/body expression) unearth other factors of ill-health and release *whānau*/family from the burdens they are experiencing? This would be an area of further research for consideration.

In the 1930s New Zealand's national health care system was established to provide free medical care by salaried medical practitioners. During this period changes in the system from a free medical care service to a government-paid fee-for-service subsidy with secondary care under state control and funding was introduced. This remained unchanged until the 1980s. As a result, the gap between Māori and non-Māori accessing health care services widened. The findings of this research found whānau (participants) who were either enabled or disabled from seeking support from their GP and/or health professional. What kept these whānau (participants) in a disabled state was through the stories passed down through generations about gout. The enabled state from observation was been released from their burden of this disease and been empowered through new knowledge about gout.

Chapter three presented the prevalence of gout among Māori and begun the search within *Te Ao Māori* (Māori worldview) reciting *whakapapa* (genealogy) as a sequential order of events, to lay one generation upon another; everything has *whakapapa* (genealogy) from the gods through to every living thing in this world that includes the mountains, rocks and land, (Barlow, C. 1991: 173). *Whakapapa* (genealogy) is critical to the wellbeing of the *whānau* (family), *hapu* (sub-tribe) and *iwi* (tribe). It is through *whakapapa* (genealogy) history unfolds, history such as health. It is here that we find ways of working with the illness, the pathway undertaken and the pathway forward, (Patterson, J. 1992: 7). *Whakapapa* (genealogy) legitimates a Māori worldview which is at the heart of Māori knowledge, Māori ways of knowing, and Māori ways of acquiring new knowledge.

It provided an overview of historical and current literature on western medical model about gout symptoms and diagnosis, the medical interventions practiced and contra indicators, (re-evaluating the course of intervention). The connection with *whakapapa* (genealogy), this disease also has a sequential order of the pathway of gout, high purine (foods), uric acid, crystallisation and a gout attack occurs. An individual or *whānau*/family may not understand the medical language about gout, but what is important to note Māori are familiar with *whakapapa* (genealogy). It is here that the clinical pathway about gout and *whakapapa* (genealogy) can interrelate and both share common factors; they have a sequential order, a history that can be learnt and recited, an insight and signposts to follow. The challenge was making the connections and seeing gout through a *whakapapa* (genealogy) lens. There have been many Māori scholars who have written on similar kaupapa (topic), one in particular that supported the direction of this thesis was Durie, M. (2004) paper; Understanding health and illness: research at the interface between science and indigenous knowledge. Durie, M. (2004) noted "*afford each belief system its own integrity, while developing approaches that can incorporate aspects of both and lead to innovative, greater relevance, and additional opportunities for the creation of new knowledge."* This was definitely the pathway that this thesis undertook using a dual paradigm approach that shaped a whakapapa model about gout.

It investigated systems thinking within the two worlds that of a *raranga* (weaving process), each woven piece connects with each other, each piece has a place in the *raranga* (weaving process), each woven piece having an integral part to the overall result. So too is the system thinking within the two worldviews demonstrating the intertwining of the two schools of thought, its integral components of connection, each level of thought contributing to the process of knowledge, and each complimenting each other. It presented a sophisticated and functional system for Māori that consisted of a powerful knowledge base, complex oral traditions, rituals and Māori worldviews that reflected the interconnectedness of the various aspects of health and development underpinned by values of *wairua* (spiritual), *manāki* (care for others) and *whānaungatanga* (maintaining the family). These values generate and transmit Māori knowledge that contributed to Māori advancement of development for future generations.

It examined the assimilation of one system through the process of the colonial policy of assimilation. Fitzroy preamble to the Native Trust Ordinance that assimilation should take place as speedily as possible in order to accelerate the process of settlement. Each successive education administration beginning in 1847 with the Education Ordinance Act rigorously pursued this policy. This policy continued into the twentieth century and was dominated by a belief that assimilation was a desirable outcome for the new colony. Bishop, R., Glynn, T. (1999) indicated that central Governments agenda and polices created and maintained a burden on Māori people to subjugate their own identity and destiny to the goals of the emerging nation, these goals were decided by the pakeha majority. According to Hauora

(1998) as a result of forced assimilation into the dominant culture practices that had originally been foreign to Māori resulted in Māori people having to act outside of the essential being of who they were as Māori. This policy was known as ‘the doctrine of assimilation’ that did not take long for the doctrine of assimilation to marginalise Māori language, traditions and health practices.

The Decade of Māori Development is a reference point for contemporary Māori development. Māori development is centred on people, rather than having a sole focus on economic growth. A distinctive feature of Māori development is that it is grounded on Māori worldviews and therefore, draws on customary knowledge. Ratima, M. (2001) suggests Māori concepts of health place a greater emphasis on holism, and are distinct in incorporating a spiritual dimension and a focus on cultural integrity. These are features that are common with other indigenous peoples’ understandings of health and, generally, Māori concepts of health are consistent with those of other indigenous peoples.

The interface of the two schools of thought was investigated into current research that indicates the attempts now being made by scientists and other thinkers to take a serious view of indigenous knowledge. Michael Warren in 1997 in a paper presented at a conference in Italy and showed the number of published case studies of indigenous knowledge in a growing number of disciplines is increasing. He listed 38 disciplines and 125 publications to demonstrate successful fusion of indigenous knowledge and science. A holistic approach which has always been the basis of indigenous knowledge systems is been accepted by many scientists and policy makers as an alternative collective wisdom within many disciplines. As these traditional systems focussed problems on the entire systems approach, that demonstrates the interlinkages and complexities, many people in the field of modern western medicine are realising the importance of including the physical, spiritual, mental, family and socio-cultural of a person when considering matters of health. Therefore, this whakapapa (genealogy) model can be adapted by other indigenous communities. However, this requires their language, cultural values and beliefs, and their history to articulate and position their bodies of knowledge.

Chapter four introduced the two methodological approaches undertaken in this thesis: kaupapa Māori and participatory action research and summarised the features of each. It was positioned that both approaches can interact in the same space together reflecting on previous research studies who have applied a dual paradigm approach. It framed whakapapa as the kaupapa Māori position with participatory action research. A w*hakapapa* (genealogy) position was the organisation of knowledge of all things that legitimates a Māori worldview, which is at the heart of Māori knowledge, Māori ways of knowing and Māori ways of acquiring new knowledge. Accordingly, a research methodology framed by *whakapapa* (genealogy) not only authenticates Māori epistemology and its rightful place among research traditions, it also supports the notion of *whakapapa* (genealogy) research methodology. The dual paradigm of KMR and PAR was the ideal framework for this research. Cram, F. (2006), further supports kaupapa Māori and participatory action research stating, "they both provide an emancipatory theory with its foundation in both western and Māori worldview and developed alongside the theories of other indigenous and minority groups who have sought a better deal from mainstream society."

PAR has been evidenced by the increased use of this approach with Māori projects over the past few years. PAR has potential for use within Māori research projects when a meaningful collaborative process. PAR principles align with many of the KMR principles of self determination, and emancipation. PAR is able to respond to the diversity of Māori and has the ability to progress Māori development. PAR is supported by a growing body of literature showing effectiveness in providing innovative solutions to health issues in a wide variety of settings (Panelli, R., et al. 2006). Both KMR and PAR are context-specific and tailored to purpose and desired outcomes (Moewaka Barnes, H. 2000, Israel, B., et al. 2003). PAR, emphasising empowerment and aligns with KMR requirement for research to be conducted in Māori ways, dealing with issues important to Māori and likely to be of benefit to them. This congruence allows incorporation of the PAR processes into a KMR framework.

The alignment of KMR and PAR was filtered through the one-to-one interviews with *whānau* (participants) and the four *wānanga*. From an observational perspective, *whānau* (participants) were empowered through sharing their stories about living with gout and their participation through *wānanga*, an opportunity to help oneself but also to *koha* (gift) their learning to others. The implementation of a *whakamā* (consciousness, facial/body expression) framework assisted in recognising what kept them silenced about gout, recognising the signposts in these states and how to overcome these states and move forward. This further supports the notions of empowerment and emancipation, to free oneself from burden.

Chapter five examined a dual paradigm approach using kaupapa Māori (Māori worldview) framed by *whakapapa* (genealogy) paradigm of *Te Kore* (the abyss), *Te Po* (voids of darkness) and *Te Ao Marama* (world of light). This framework assisted in describing behaviours and characteristics of gout sufferers and was seen as offering a wealth of concepts, principles and values that are used and applied through time. The key concepts were viewed as strongly influencing the attitudes and behaviour of Māori people today and underpin the way Māori deal with the world and influences many ideals and actions. It is a traditional Māori framework that reaches the heart of Māori and other indigenous and non- Māori peoples,' positions thought and understanding making connections through *whakapapa* (genealogy).

It is a tool to transmit bodies of knowledge through generation to generation, makes sense of the characteristics and behaviours of whānau groupings by tracing the blueprints of the footsteps of ancestors. It is a language that is mostly understood among Māori communities to enhance the wellbeing of people, as *whakapapa* (genealogy) paradigm has a purpose and reason for being; processes towards conscientisation, engage thought, reflection, interest, excitement and willingness. This in turn leads to dialogue, discussion, debate, creates reference points, creates tensions, creates challenges, encourages courage and pursues enlightenment.

It has an order, a guide to live life by, a way to move forward, a plan with strategies of wellbeing, and a notion of evolving through time and an understood response to challenge. It has a process of rationalising ideas through one's deepest thoughts, having key parameters, has reasoning, logic and explanation and has a universal approach to themes from local angles. Whakapapa (genealogy) paradigm has an intent, rules, standards, and ways of doing, ethics and why and how they are created. There are many interpretations, many re/constructions and many contexts and sites. Whakapapa (genealogy) paradigm therefore, has constructions of order, cultural thinking, represented through its language, located in its structures and systems, the location of conventions and rationales. Finally, Marsden, M. (1977) asserts Māori worldview as:

> *"The centre is where he must create himself an orderly system of ideas about himself and the world, in order to regulate the direction of life."*

The Māori human development framework tracked stages of growth and development and was viewed as a process that unfold bodies of knowledge found within the *whakapapa* (genealogy). On one level the *whakapapa* (genealogy) paradigm recognised behaviour and characteristics of a gout sufferer, while the Māori human growth and development signposted these behaviours and characteristics. *Te Pu*, (root cause) signposts that individuals inappropriate behaviour has a root cause, *Te Weu* (rootlets or the offshoots) signposted side issues that are related and intertwined to the root cause of behavioural influences, *Te More* (taproot or the main arterial root) signalled the root that can cause a diversion in growth, *Te Aka* (the vine) determines the quality of the vine, *Te Tipuranga* (symbolises growth) shapes ethical behaviour and produces nutrients for long-term survival. The results from all whanau verbatim found patterns of disablement (whakapapa), "we don't say the word gout, just put up with the pain, never talked about gout, it's a shameful disease that keeps you silenced, I isolated myself, it's a crippling disease, it makes you feel so burdened.' The behavioural patterns (Maori human growth) highlighted, '*put up with gout, kept silent, say nothing, self-image of manhood, do not show your emotions, language barrier, don't complain*.'

The second section explored the clinical process of gout through the chemical imbalances, uric acid, crystallisation and a gout attack. Out of interest the clinical pathway on gout depicted a *whakapapa* order; chemical imbalance, if an individual is at risk of gout, diet was an essential key; the *whānau* purine is a protein and the whakapapa connects to food, in particular red meat and seafood. The by-product of that breakdown is uric acid which most of the time is converted to the soluble form which is a salt called urate which we excrete through the kidneys. However, if the *whānau* kidney is unable to breakdown the high levels of purine the whānau uric acid arrives, the cousins carbon, nitrogen, oxygen, hydrogen take form and the whānau crystallisation arrives. The whānau calcium and kidney stones are related to each other because some types of kidney stones are caused by a build-up of calcium in the kidneys. When calcium crystallizes in the kidneys, kidney stones tend to form and the onset is a gout attack. Through the Wānanga, the focus of all this information was challenging for whānau (participants), however, the challenge became a driving-force, a sense of empowerment that appeared to keep whānau (participants) focussed. The whānau (participants) drew from their worldview and discussed how they retained information within their own whānau/family and the consensus was waiata (song) been a central point of learning.

An interesting point of reference was the transformative process of learning that occurred through waiata. Music has been in Māori *whakapapa* (genealogy) since time began through marae, mythology and haka and reflects the practices, customs and musicological aspects of Māoridom. The evidence of music as a form of uplifting and connecting all New Zealanders as a nation is the haka performed by the All Blacks. Furthermore, it has been evidenced that the power of music has the ability to reach out and help people develop their potential, whatever their health, disabilities and or difficulties. It is even more powerful when it comes to healing indigenous people. As a result, whānau (participants) developed a waiata (contemporary song) called "The Pathway of Mr. Gout." This waiata (contemporary song) illustrates and articulates the whānau (participants) ability to retain, learn and understand from a Te Ao Māori (Māori worldview) position the disease gout.

The final section brought together a dual paradigm framework within the two worldviews: *whakapapa* paradigm, Māori human growth and development, clinical process for gout, demonstrating the intertwining of the two schools of thought, its integral components of connection, each level of thought contributing to the process of knowledge, and each complimenting each other. This line of thinking Marsden, M. (2003) asserts as a world of Māori cosmogony providing interrelated topics of knowledge that provide sanctions, protocols and guidelines through Māori worldviews and value systems. It portrays an understanding of holistic approach and the fundamental principles of Māori customs to everyday life that integrates into the value systems of culture. The dual paradigm framework accessing both systems and use the insights and methods of one to enhance the other. The focus therefore provides a paradigm shift from proving the superiority of one system over another to identifying opportunities for combining both. Durie, M. (2004) in his paper illustrated how Māori health researchers in New Zealand have been able to draw on both systems in order to conduct research that has credibility in scientific and cultural terms.

Chapter Six explored whakamā (inner consciousness, facial/body expressions) as a guiding principle to unearth myths about gout. There were two specific themes that evidenced *whakamā*; the stories that were passed down through generations that had a devastating effect to the decision-making process for whānau (participants) seeking support for their gout through a GP or health professional. The other factor for all male participants was self-perception of man-hood with this disease; the states of feelings held *"shame, burden, handle it, get on with it, don't show your emotions"* appeared to suppress their man-hood, limit them seeking understanding for this disease because they did not want to appear 'weak.'

The depth and breadth of whakamā was examined through pre/post whakamā questionnaires, powerful messages emerged that brought to the surface the depth and breadth of whakamā. These messages were transmitted through stories, self-perception of manhood and the limited knowledge known about gout, it appeared they were in a 'petrified state,' that dislocated them from engaging in dialogue. This state of being 'petrified' was likened from the male participants in this research to the Goddess Medusa. The main focal point was the curse of being able to turn men into stone; it was not the fact of turning men into stone they are referencing but more the frozen concretised state; the state of silence, the state of shame, the state of manhood. This state was further supported in the whakapapa (genealogy) paradigm of Te Kore (abyss) the realm between non-existence, representing non-engagement, fear of movement, and existence, the realm of potential. *Te Po* (voids of darkness) signposts emptiness and darkness of the mind due to limited light and knowledge. In this instance the fear of movement of understanding gout and its effects to one's being. Te Ao marama (world of light) that articulated and signalled signposts of Whakamā patterns of behaviour and states of being, a paradigm shift of thinking to change the fear of non-movement or delayed potential, to the realm of potential, to the realm of possibilities.

It was evident that *whakamā* (inner consciousness, facial/body expression) as a guiding principle provided indicators that unearthed myths about gout, unearthed inner consciousness of states of being and unearthed patterns of behaviours. Furthermore, *whānau* (participants) strongly emphasised in the development of the *whakapapa* (genealogy) model, *whakamā* must have a place. The discussions and insights about *whakamā* (inner consciousness, facial/body expression) they have learnt has contributed to them shifting to a position of being enabled to seeking support for their gout.

Chapter seven explored the development of a whakapapa model about gout through a *wānanga* approach and applied a reflective process to the learning. This process of *wānanga* and reflective process provided *whānau* (participants) the potential to develop frameworks that would contribute to the overall *whakapapa* (genealogy) model about gout. The first *wānanga*, a *whakamā* (inner consciousness, facial/body expressions) framework emerged offering further insight in its construct and signposts signalling states that must be considered when working with Māori sufferers of gout. This framework provided experiences from the *whānau* (participants) that signalled states of feeling/emotions, behavioural responses, consequences that connected to shades of *whakamā* (inner consciousness, facial/body expression). Furthermore, selected questions relating to *whakamā* (innerconsciousness, facial/body expression) were considered and contributed to the shape and the design the pathway of *whakamā* (innerconsciousness, facial/body expression) will undertake. The development phases of this process are captured in Raelin, J. (2002) stating:

> *"Reflection is an active process of witnessing one's own experience in order to take a closer look at it, sometimes to direct attention to it briefly, but often to explore it in greater depth."*

The second *wānanga* was to explore the clinical process about gout, its pathway through the body and signalled its importance within the *whakapapa* (genealogy) model. Whilst this section of the *wānanga* was a challenge through learning of new knowledge, understanding and contextualising its processes, an amazing transformation occurred for whānau (participants). They drew from their own 'knowing' and their own experiences and transformed the challenge into a space for potential learning and growth. From observation, the Wānanga environment provided the transmission of bodies of knowledge to flow freely, their engagement with others in the process of whānaungatanga (interrelationships) and illustrated this learning from a Māori worldview position. The talents of *whānau* (participants) transposed a challenge and placed the challenge into an area of familiarity and as noted previously, was the creation of a waiata (contemporary song). This style of learning can be located into Māori worldview and as noted previously, Grey, G. (1953) asserted that a major rationale for his collecting the songs and stories was they came from the bedrock and knowledge base for Māori.

The third *wānanga*, the emerging of another framework took shape and that was the *whakapapa* (genealogy) paradigm of *Te Kore* (abyss), *Te Po* (voids of light) and *Te Ao Marama* (world of light). This framework articulated and signalled signposts of gout behaviours, characteristics and states of being and its connections with Buck, T.H. (1949) growth model, *Te Pu* (root cause), *Te Weu* (rootlets), *Te More* (taproot), *Te Aka* (vine) and *Te Tipuranga* (growth), that connects behaviour and lifestyles requiring consideration for recovery. It signified dimensions that merge together showing an overlapping of interconnected relationships. The final *wānanga* offers a *whakapapa* (genealogy) model about gout and has been further developed into a six-week programme for gout suffers. It also has frameworks to measure a paradigm shift of thinking through pre and post questionnaires.

The significance of developing a *whakapapa* (genealogy) framework has become a fundamental aspect of the way Māori think about and come to know the world, (King, M.1981). *Whakapapa* (genealogy) is acknowledged as a way of thinking, a way of storing knowledge and a way of debating knowledge, (Smith, L.T. 1999). This process *whānau* (participants) positioned *whakapapa* (genealogy) as a means and way to acquire new knowledge and more significantly applying *whakapapa* (genealogy) principles with a clinical process about gout. This framework addressed many levels for gout sufferers one in particular is the presentation of health literacy about gout. As noted previously in chapter two, Māori data represented eighty percent (80%) of Māori male and seventy four percent (74%) Māori female rates (per 100,000) did not have the ability to obtain, process and understand basic health information in order for them to make an informed decision about their health (Ministry of Health, 2010).

This framework has the ability to assist gout sufferers and their *whānau*/family comprehend the complex issues they face in a language that they understand. Furthermore, this framework provided key messages most relevant to their needs and culturally addressed areas that would not be considered in normal health literacy i.e. addressing *whakamā* (inner consciousness, facial/body expression) as a guiding principle to unearth myths about gout in *whānau*/family, alignment of *whakapapa* (genealogy) and the clinical process about gout. In a recent review by the Ministry of Health (2012: 3) on health education resources for gout medication summary stated:

> *"Good health literacy also includes a person having a good knowledge of how the human body works, as well as knowledge of specific health conditions, a strong relationship between a person's health literacy and their health status."*

This framework is shaped to accommodate such learning and more importantly transforming that learning into helping whānau with gout, this line of thinking is further supported by the Ministry of Health[20] stating:

> *"Resources and health literacy need to be written or scripted using language and concepts that work for the target audience. Making a resource understandable is not about 'dumbing down' or reducing information; it is about health professionals being more responsive to the needs of their patients and taking a patient and whānau-centred approach to all forms of information. It is about giving people the*

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[20] Ibid: 4

> *information they need, when they need it, in a form that makes sense to them. Once people have acquired the most important concepts and knowledge, then new information can be added to develop a person's understanding of their condition and treatment"*

This statement aligns and connects to the development of a *whakapapa* (genealogy) model about gout that ensured *whānau* (participants) could easily understand the programme as they were the main authors of this model, they contributed to the development of frameworks that made sense from their worldview, demonstrating ways of having conversations with whānau/family and access to health professionals, having the ability to recognise signposts for themselves.

At every level *wānanga* and reflective process occurred. The central focal point and power of transformative learning was a fundamental change in perspective that transformed the way whānau (participants) understood and interacted with each other. This was evidenced through the development of frameworks that would contribute to the overall *whakapapa* (genealogy) model about gout. Through this process *whānau* (participants) were questioning their beliefs, values and assumptions relating to gout and discovered new perspectives and strategies to help not only them but their extended whānau/family.

With any new development are limitations, whilst this model served well among the fifty participants in this research. Further investigation is required to test this model to a larger audience. The testing ground of consideration should be South Auckland, New Zealand where reported cases of gout among Māori 9.3%. At this point in time, discussions are already underway with one of the Māori health providers who supported this research, to offer the *whakapapa* (genealogy) model about gout programme to all sufferers of gout and their *whanau*/family.

Te Ara Piki ki Rangituhaha (the pathway in the journey of discovery/destiny)

Te Ara (pathway) positioned and articulated the Health status of Māori in Aotearoa and the literature review of the prevalence of gout among Māori. It provided a platform to gain a depth of understanding about this pathway of gout suffers.

Piki ki (journey) drew from a dual paradigm approach using Māori and Western bodies of knowledge and applied a methodological approach of engagement through kaupapa Māori whakapapa and participatory action research. The dual paradigm approach continued into a whakapapa and clinical process about gout. A transformation of learning occurred during this process, a sense of connection, understanding and a way forward to engage with the whānau (participants).

Rangituhaha (discovery/destiny) contextualised the transformation of learning through one-to-one whānau (participants) interviews and Wānanga. The pathway of learning through observation was transformed and *Te Ara* (the pathway) and *Piki ki* (journey to) contextualised this meaning, purpose and understanding for the whānau, we welcomed each other to *Rangituhaha* (discovery/destiny).

There will be ways and techniques that will always fashion the way we master and transform experiences into learning. There will always be signposts to indicate this pathway, there will always be *hoa haere* (companions) that we will invite to journey and lead, teach and master. This is the sense of my ‘knowing’ if one is able to provide meaning, purpose and fulfilment for others to feel inspired, valued and empowered then this journey is worth all the sleepless nights.

This journey was represented from all whānau (participants) in this research what is this key? They held their key, they accepted their own obligations to the key, they accepted their own responsible for the key, they accepted their own accountable for the key, they found their own KEY. They helped and supported each other in unlocking the pathway and journey to Rangituhaha, the pursuit of their own mauri ora (wellbeing). What an honour and blessing to have shared in this journey with the whānau (participants) and I too was responsible for MY KEY. The never ending journey of learning is a life-time commitment and this journey is far from completion it has just begun.

BIBLIOGRAPHY

Ameratunga, S., Waayer, D., Robinson, E., Clark, T.C., Crengle, S., Denny, S., Sheridan, J., Teevale, T. (2011). Youth'07: The Health and Wellbeing of Secondary School Students in New Zealand. Young People and Alcohol, Auckland, New Zealand: The University of Auckland, Adolescent Health Research Group.

Barlow, C. (1991). Tikanga Whakaaro: key concepts in Māori culture. Oxford University Press, Auckland.

Best, E. (1924). The Māori Vol.I. Published by The Board of Māori Ethnological Research for the Author and on behalf of the Polynesian Society. Harry H. Tombs, Limited, at their Registered Printing Works.

Bird, L., Drewery, W. (2000). Human development in Aotearoa: A journey through life. Auckland, New Zealand: McGraw-Hill.

Bishop, R., Glynn, T. (1999). Culture Counts Changing Power Relations in Education. Palmerston North: The Dunmore Press Ltd.

Brougham, A.E., Reed, A.W., Karetu, T.S. (1987). Māori proverbs, Auckland, Heinemann Reid.

Buck, P. (1949). The Coming of the Māori, (reprinted, 1974). Whitcombe and Tombs.

Coleridge, S.T. (1983) Biographia Literaria (J Engell and WJ Bates, eds). Princeton University Press: Princeton NJ. (Originally published 1817)

Churchill, W. 1996. From a native son: selected essays on indigenism, 1985–1995. Boston: South End Press.

Cornell, S., Kalt, J. (1997). 'Successful economic development and heterogeneity of governmental form on American Indian reservations', in Grindle. M. (ed.), Getting good government: capacity building in the public sectors of developing countries, Cambridge, Harvard University Press.

Cornell, S., Gil-Swedberg, M. (1995). 'Socio-historical factors in institutional efficacy: economic development in three American Indian cases', Economic Development and Cultural Change, 43, 2, 239-267.

Crengle, S. (1997). Ma Papatuanuku, ka Tipu nga Rakau: A Case Study of the Well Child Health Programme Provided by Te Whanau o Waipareira Trust, Master of Public Health thesis, University of Auckland, Auckland.

Durie, M. (2003). Nga Kāhui Pou Launching Māori Futures. Wellington, Aotearoa/New Zealand. Huia Publishers.

Durie, M. (2001). Mauri Ora The Dynamics of Māori Health. Oxford University Press.

Durie, M. (1998). Te Mana, Te Kawanatanga: The Politics of Māori Self-Determination. Auckland, New Zealand: Oxford University Press Inc.

Durie, M. (1998). Whaiora: Māori Health Development, 2^{nd} Edition, Oxford University Press, Auckland.

Durie, M. (1998b). Te mana, te käwanatanga, the politics of Mäori self-determination, Auckland, Oxford University Press.

Durie, M. (1998c), Whaiora: Mäori health development (Second Edition), Auckland, Oxford University Press.

Durie, M. (1994). Whaiora: Māori Health Development. Auckland, New Zealand: Oxford University Press Inc.

Edwards, S. (2009). Titiro Whakamuri Kia Marama Ai Te Wao Nei: Whakapapa Epistemologies and Maniapoto Māori Cultural Identities. A Thesis submitted in fulfilment of the requirements of the degree of Doctor of Philosophy, Massey University.

Eruera, M. (2005). He Kōrero Korari: Supervision for Māori. Weaving the past, into the present for the future. Masters Thesis, Massey University. Auckland.

Fals-Borda, O. (2001). Participatory (action) research in social theory: Origins and challenges. In P. Reason & H. Bradbury (Eds.), Handbook of action research (pp. 27-37). London: Sage.

Fals-Borda, O., Rahman, M. A. (1991). Action and knowledge:Breaking the monopoly with participatory action research. London: Intermediate Technology Publications, New York: Apex Press.

Fanon, F. (1963). The Wretched of the Earth. Grove Weidenfeld Publisher.

Friere, P. 1998. Pedagogy of Freedom. Rowman and Littlefield Publishers, Lenham, Maryland.

Frost, R. (1963). Classic Poetry Series: Robert Frost Poems. Republished 2004, Poemhunter.com.

Grey. G. (1995). Polynesian Mythology and Maori Legend. Waikato Print, Hamilton, New Zealand. P.p. 1-9.

Hudson, M. (2004). He Matatika Maori. Maori and Ethical Review in Health Research. Thesis submitted Auckland University of Technology Degree of Masters in Health Science.

Iwikau, B. (2005). Te Toi O Matariki: A Cultural Model for Personal Growth And Development. Unpublished thesis, Auckland University of Technology degree of Masters of Arts.

Jahnke, H., Taiapa, J. (2003). "Mäori research" in C. Davidson and M. Tolich (eds.) Social Science Research in New Zealand: Many Paths to Understanding, Pearson, Auckland.

Jensen, P., Bacal, K., Crengle, S. (2008). He Ritenga Whakaaro: Māori experiences of health services, Auckland, Māori ora Associates. Printed by Proclaim Solutions Group, first printed January 2009.

Karetu, T.S. (1987). Māori Proverbs. Revision of work by A.E. Brougham and A.W. Reed. Auckland, Reed Methuen.

Kawagley, A.O. (1995). A Yupiaq worldview: a pathway to ecology and spirit, Prospect Heights, IL, Waveland Press Inc.

Kenyon, G.M., Randall, W.L. (1997). Restorying our lives: Personal Growth through Autobiographical Reflection. Westport, CT: Praeger.

Kiro, C.A. (2000). Kimihia mo te Hauora: Māori Health Policy and Practice [dissertation]. Wellington, New Zealand: Massey University.

King, M. (ed.) (1981). Te Ao Hurihuri: The World Moves On - Aspects of Māoritanga. Auckland: Longman Paul Ltd.

Kohere, R.T. (1951). He Konae Aronui, Māori Proverbs and Sayings. A.H. & A.W. Reed, Wellington.

Kolb, D.A. (1984). 'Experiential Learning experience as a source of learning and development', New Jersey: Prentice Hall

Kerr, S., Liane, P., Moewaka Barnes, H., McCreanor, T. (2009) 'Kaupapa Maori Action Research to improve heart disease services in Aotearoa, New Zealand', Ethnicity & Health.

Kunitz, S.J. (1994). Disease and Social Diversity. The European Impact on the Health of Non-Europeans. New York, NY: Oxford University Press Inc.

McQueen, H. (1993). Education is change 20 viewpoints. Wellington: Williams Books Ltd.

MacDonnel, D. (1986). Theories of discourse: An introduction. Oxford and Cambridge, UK: Basil Blackwell.

McNeill, H. (2005). Te Hau Ora o Nga Kaumatua o Tuhoe – Tuhoe Kaumatua Mental Wellness. Thesis submitted for Doctor of Philosophy. Auckland Universtiy of Technology.

Mahuika, A. (1981). Leadership Inherited and Achieved in Te Ao Hurihuri: The World Moves On. Edited by Michael King, Longman Paul, Auckland.

Marsden, M. (2003). The Woven Universe. The Estate of Rev. Māori Marsden. P.p.54-72.

Marsden, M. (1985), 'God, man and the universe: a Māori view', in King, M. (ed.), Te Ao HuriHuri, Auckland, Longman Paul.

Marsden, M. (1977). God, Man and Universe: A Māori view. Cited in King 1977 (editor). Te Ao Hurihuri: The World Moves on. Revised edition, New Zealand, Hicks Smith and Methuem, pp. 147-194.

Mead, H. (2003). Tikanga Māori. Huia Publishers, New Zealand.

Mead, H. (2003). Nga ahi e ngiha mai nei. The fires that flare up. In Tikanga Māori. Living by Māori values. Wellington: Huia. p350

Metge. J 1986. In and Out of Touch - Whakamaa in Cross Cultural Context. Victoria University Press, Wellington.

Ministry of Health. (2012). Review of Health Education Resources on Gout Medication: Summary of report to the Ministry of Health. Wellington. Published in June 2012 by the Ministry of Health, New Zealand.

Ministry of Health. (2010). Korero Marama: Health Literacy and Ma ori. Results from the 2006 Adult. Literacy and Life Skills Survey. Wellington.

Ministry of Health. (2010) (2nd ed). Tatau Kahukura: Māori Health Chart Book, Wellington.

Ministry of Health. (2009a). A Focus on the Health of Māori and Pacific Children: Key findings of the 2006/07 New Zealand Health Survey. Wellington.

Ministry of Health. (2009b). Kia Tika Ka Ora: The Ma¯ori health provider work programme 2009–2010. Wellington.

Ministry of Health. (2008). A Portrait of Health. Key results of the 2006/0 New Zealand Health.

Ministry of Health. (2006). Tatau Kahukura: Māori Health Chart Book, Public Health Intelligence monitoring report no. 5. Wellington.

Ministry of Health and University of Otago. (2006). Decades of Disparity III: ethnic and socioeconomic inequalities in mortality (1981-1999). Wellington, New Zealand.

Ministry of Health. (2004). Ethnicity Data Protocols for the Health and Disability Sector. Wellington, New Zealand.

Ministry of Health. (2003). Food and Nutrition Guidelines for Healthy Adults: A background paper. Wellington, New Zealand.

Ministry of Health, (2002). He Korowai Oranga: Māori Health Strategy. Wellington, New Zealand.

Ministry of Health. (2002). Reducing Inequalities in Health. Wellington: New Zealand.

Ministry of Health. (2002). The New Zealand Health Strategy. Wellington, New Zealand.

Ministry of Health. (2001). The Primary Health Care Strategy. Wellington, New Zealand.

Ministry of Health. (2000). Literature Review of Programme Effectiveness for Alcohol & Drugs. Public Health Directorate, Ministry of Health, Wellington, New Zealand.

Ministry of Health. (1999). Taking the Pulse: The 1996/97 New Zealand Health Survey. Wellington, New Zealand.

Ministry of Health. (1999). Our Health, Our Future (1999). Hauora Pakari, Koiora Roa. The Health of New Zealanders, Wellington, New Zealand.

Minkler, M., Wallerstein, N. (Eds.). (2003). Community based participatory research in health. San Francisco: Jossey-Bass.

Nepe, T. (1991). E Hao ne e tenei Reanga: Te Toi Huarewa Tipuna, Kaupapa Māori, An Educational Intervention, Unpublished Master of Arts thesis, University of Auckland, Auckland

Neuhauser, P.C. (1993). Corporate Legends and Lore: The Power of Storytelling as a Management Tool. New York: McGraw-Hill.

Nicoll, D., McPhee, S.J., Pignone, M. (Eds) (2001). Pocket Guide to Diagnostic Tests, 3rd. McGraw-Hill, New York, NY, United States.

Office for Disability Issues and Statistics New Zealand. (2010). Disability and Maori in New Zealand in 2006: Results from the New Zealand Disability Survey. Wellington: Statistics New Zealand.

Paki, V.A. (2007). Kimihia, Rangahau nga tikanga heke iho. He taonga huahua e riro mai. Exploring whakapapa as a tool towards a kaupapa Māori assessment framework in early childhood education. A thesis submitted in partial fulfilment of the requirements for the degree of Master of Education at The University of Waikato.

Paraha, G. (1993). He Pounamu Käkano Rua: Construction of Mäori Women: A Visual Discourse, MA thesis, University of Auckland, Auckland.

Patterson, J. (1992). Exploring Māori Values. The Dunmore Press Limited. P.p. 155-182.

Pihama, L. (2001). Tihei Mauri Ora: Honouring Our Voices. Mana Wahine as a Kaupapa Mäori Theoretical Framework. Unpublished PhD, The University of Auckland.

Poata-Smith, T. (2004). The changing contours of Māori identity and the Treaty settlement process. In Hayward, J. and Wheen, N. (eds) The Waitangi tribunal, te roopu whakamana I te tiriti o Waitangi. Wellington: Bridget William Brooks. p171

Poata-Smith, E.S.T.A. (1996). 'He pokeke uenuku i tu ai - the evolution of contemporary Māori protest', in Spoonley, P., Pearson, D. and Macpherson, C. (eds.), Nga patai - racism and ethnic relations in Aotearoa/New Zealand, Palmerston North, Dunmore Press.

Pohatu, T.W. (1999). Ata: Growing Relationships. He Pukenga Kōrero, A Journal of Māori Studies, Volume 8, No, 1, pp 1-8, 2004, ISSN 1173-5767.

Pool, I. (1991). Te Iwi Maori: A Population Past, Present and Projected. Auckland Oxford University Press.

Pomare, E.W. (1980). Māori Standards of Health: A Study of the 20-Year Period 1955–75. Wellington, New Zealand: Medical Research Council of New Zealand.

Pomare, E.W., Keefe-Ormsby, V., Ormsby, C. (1995). Hauora: Māori Standards of Health III. A Study of the Years 1970–1991. Wellington, New Zealand: Eru Pomare Māori Health Research Centre.

Pomare, E.W., Tutengaehe, H., Ramsden, I., Hight, M., Pearce, N., Ormsby, V. (1991). He Mate Huango: Māori Asthma Review. Wellington, New Zealand: Huia Publications.

Polanyi, M. (1967). The tacit dimension. Doubleday: New York.

Prytz, J.J. (1954). The Māori and his Religion in its non-ritualistic aspects. Ejnar Munksgaard: Copenhagen

Ramsden, I. (2002). Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu, Dissertation. Wellington, New Zealand: Victoria University of Wellington.

Randall, R.L. (1996). Restorying a Life: Adult Education and Transformative Learning. In Aging and Biography: Explorations in Adult Development, edited by J.E. Birren et al, pp. 224-247. New York: Springer Publishing.

Ratima, M. (2001). Conceptualising Māori Health Promotion. A Thesis submitted for the Degree of Doctor of Philosophy of the University of Otago, Dunedin, New Zealand.

Ratima, M. (2001). Kia Ururu mai a Hauora: Being Healthy, Being Māori. Conceptualising Māori Health Promotion [dissertation]. Otago, New Zealand: University of Otago.

Reason, P., Bradbury, H., (eds). (2006). Handbook of action research. London: Sage.

Reason, P., Bradbury, H. (Eds.). (2001). Handbook of action research: Participative inquiry and practice. London: Sage Publications.

Reid, P. (1998). The impact that Māori have made on health and society in New Zealand. Health and Sociey. K.P.D. Davis. Auckland, Oxford University Press.

Reid, P., Robson, R. (2007). Understanding health inequities. In: B. Robson and R. Harris, eds. Hauora: Māori standards of health IV. A study of the years 2000_2005. Wellington: Te Ropu Rangahau Hauora a Eru Pomare, 3_5.

Reid, P., Robson, B. (2006). The state of Māori health. In M. Mulholland, (ed). State of the Māori Nation: Twenty-First Century Issues in Aotearoa: Reed.

Rose, B. Prior, I.A.M., Davidson, F. (1968). In: Population Studies of the Rheumatic Diseases, Ed. P.H. Bennett & P.H.N Wood. Amsterdam. P. 344.

Royal, T. A. (2003). The woven universe - Selected writings of Rev. Māori Marsden. Otaki: Estate of Rev. Māori Marsden.

Salmond, A. (1997). Between worlds: Early exchanges between Māori and Europeans. Auckland: Penguin Books (NZ) Ltd.

Salmond, C., Crampton, P. (1999). Deprivation and health. In: Howden-Chapman P, Tobias M, (eds). Social Inequalities in Health: New Zealand. Wellington, New Zealand. Ministry of Health; 2000:9–63.

Sarantakos, S. (1993). Social Research (Second Edition), Basingstoke, Macmillan.

Schon, D. (1987). Educating the Reflective Practitioner. Jossey-Bass: San Francisco.

Schon, D. (1983). The reflective practitioner. Basic Books: New York

Selby, R. (1999). Still Being Punished. Wellington, New Zealand, Huia Publisher.

Shirres, M. (1977). Te Tangata – the Human Person. Accent Publications, Auckland.

Smith, G.H. (2000). Protecting and Respecting Indigenous Knowledge. In M. Battiste (ed), Reclaiming Indigenous voice and vision. Vancouver, Toronto: UBC Press.

Smith, G.H. (1990). Taha Mäori: Päkehä Capture. In J. Codd, R. Harker & R. Nash (Eds.), Political Issues in New Zealand Education. Palmerston North: Dunmore Press. p.100.

Smith, L. T.(1999). Decolonising methodologies research and indigenous peoples. Dunedin: University of Otago Press.

Smith, L.T., Cram, F. (1997). An evaluation of the Community Panel Diversion Pilot Project. Commissioned by the Crime Prevention Unit, Office of the Prime Minister and Cabinet, Wellington.

Statistics New Zealand. (2005). Ma ori Population: Looking out to 2021. Hui Taumata Wellington.

Statistics New Zealand. (2004). Reference Reports, 2001 Census: Māori 2001 Highlights. Wellington, New Zealand.

Stewart, T. (1997) "Historical interfaces between Mäori and Psychology" in P. Te Whäiti, M. McCarthy and A. Durie (eds.) Mai i Rangiätea: Mäori Health and Wellbeing, Auckland University Press, Auckland.

South Commission. (1990). The challenge to the South: the report of the South Commission, Oxford, Oxford University Press.

Taylor, R. (1855). *Te Ika a Maui.* Wertheim & Macintosh, London.

Te Awekotuku, N. (1991). He Tikanga Whakaaro: Research Ethics in the Mäori Community, Ministry of Mäori Affairs, Wellington.

Te Puni Kokiri. (1992). Nga Toka Tuu Moana:Māori Leaderhsip and Decision-Making: Part II Traditional Māori Social Groups, Part IV Modern Māori Leadership and Decision-Making and Part V Guidelines an Principles for Māori Leadership and Decision Making 24 November 1992. Prepared by Ngaa Tuaraa, Te Puni Kokiri, Wellington.

Walker, R. (1992). Māori Political Development, in New Zealand Politics in Perspective. Edited by Hyman Gold, Longman & Paul Ltd, Auckland.

Walker, R. (1990). Ka whawhai tonu Matou, struggle without end, Auckland, Penguin Books.

Walker, R. (1985). Cultural domination of Taha Maori: The potential for radical transformation. In J. Codd & R. Nash (Eds.). Political issues in New Zealand Education (pp.73-79). Palmerston North, New Zealand: Dunmore Press.

Walsh, N.D. (1995). Conversations with God: An Uncommon Dialogue, Book 1. Emnin Books, Ashland.

Warren, M.D. (1997). The Domestic of Knowledge and Practical Uses: Conference Paper, Venice Italy.

Williams, H.W. (2000). Dictionary of the Māori Language. Legislation Direct, Wellington, 7th Edition: 1971, rep 2000) 416.

Wittgenstein, L. (1953). Philosophical Investigations (GEM Anscombe, translator). Macmillan: New York.

Wyeth, E.H. (2007). Hauhaketia To Wahia I Mua I Te Takurua. Māori and Genetic Health Reseach: A Case Study. A thesis submitted for the degree of Doctor of Philosophy (PhD) in Genetics. University of Otago, Dunedin, New Zealand.

JOURNAL ARTICLES

Ajwani, S., Blakely, T., Robson, B., Tobias, M., Bonne, M. (2003). Decades of Disparity: ethnic mortality trends in New Zealand 1980–1999. Wellington: Ministry of Health and University of Otago.

Baker, J.F., Krishnan, E., Chen,L., Schumacher, H.R. (2005). Serum Uric Acid and Cardiovascular Disease: Recent Developments, and Where Do They Leave Us? AM J Med. 118:816-26.

Baxter, J. (2002). Barriers to Health Care for Māori With Known Diabetes. A Literature Review and Summary of Issues. Wellington, New Zealand: New Zealand National Working Group on Diabetes.

Bishop, R., Glynn. T. (1992). He Kanohi Kitea: published New Zealand Journal of Educational Studies.

Black, S.S. (1996), 'Indigenous economics', Winds of Change, Autumn, 66-69.

Blakely, T., Tobias M, Atkinson J, et al. (2007). Tracking Disparity: Trends in ethnic and socioeconomic inequalities in mortality, 1981–2004. Wellington: Ministry of Health.

Blaiklock, A.J., Ciro., C.A., Belgrave, M., Low, W., Davenport, E., Hassall, I.B. (2002). When the Invisible Hand Rocks the Cradle: New Zealand Children in a Time of Change. Florence, Italy: Innocenti Research Centre; Working paper 93.

Blumenthal, D. S., DiClemente, R. J. (2004). Community-based health research: Issues and methods. New York: Springer.

Brauer, G., Prior, I.A.M. (1978). A prospective study of gout in New Zealand Māoris. Annals of the Rheumatic Diseases, 37, 466-472. From the Epidemiology Unit, Wellington Hospital, New Zealand.

Braveman, P., Gruskin, S. (2003). Defining equity in health. Journal of Epidemiology and CommunityHealth 57: 254–258.

Branch, W. T., & Paranjape, A. (2002). Feedback and reflection: Teaching methods for clinical settings. Academic Medicine , *77*(12), 1185-1188.

Brown, L., Vega, W. (2003). A protocol for community based research. In M. Minkler & N. Wallerstein (Eds.), Community based participatory research in health (pp. 407-409). San Francisco: Jossey Bass.

Buchanan, B. R., Miller, F. G., Wallerstein, N. B. (2006). Ethical issues in community based participatory research: Balancing rigorous research with community participation. Manuscript submitted for publication.

Chang, S.J., Ko, Y.C., Wang, T.N., Chang, F.T., Cinkotai, F.F., Chen, C.J. (1997). High prevalence of gout and related risk factors in Taiwan's Aborigines. The Journal of Rheumatology. 24(7): 1364-9.

Chavunduka, G. (1999). Paper presented at the Research Council of Zimbabwe National Consultative Workshop on Impact of Biotechnology on Agriculture and Health: Kadoma Hotel, Mt Pleasant, Harare.

Choi, H.K., Atkinson, K., Karlson, E.W., Willett, W., Curhan, G. (2004). Purine-rich foods, dairy and protein intake and the risk of gout in men. N Engl J Med. 350.11. P.p 1093-1103.

Choi, H.K., Liu, S., Curhan, G. (2005). Intake of purine-rich foods, protein and dairy products and the relationship to serum levels of uric acid: the Third National Health and Nutrition Examination Survey. Arthritis Rheumatology. 52.1 P.p. 283-289.

Clark, T.C., Robinson, E., Crengle, S., Grant, S., Galbreath, R.A., Sykora, J. (2009). Youth’07: The Health and Wellbeing of Secondary School Students in New Zealand. Findings on Young People and Violence. Auckland: The University of Auckland.

Commission on Social Determinants of Health. (2008). Closing the Gap in a generation: health equity through action on the social determinants of health. Final Report. World Health Organisation.

Commission on Social Determinants of Health. (2007). Achieving health equity: from root causes to fair outcomes. Commission on Social Determinants of Health, IER/EQH. Geneva: World Health Organization.

Cornell, S. (1995), 'Where does economic development really come from? Constitutional rule among the contemporary Sioux and Apache', Economic Inquiry, 23, 402-426.

Cram, F. (2006). Talking Ourselves Up. Alternative: an International Journal of Indigenous Scholarship, University of Auckland, New Zealand.

Cram, F. (2001). "Rangahau Mäori: Töna tika, töna pono – The validity and integrity of Mäori research" in M. Tolich (ed.) Research Ethics in Aotearoa New Zealand: Concepts, Practice, Critique, Longman, Auckland.

Cram. F. (1997). Māori-Pakeha Teamwork in Māori Health Research et al. Sites No. 33 (Spring): 44-63 and International Research Institute for Māori and Indigenous Education; University of Auckland.

Cram, F. (1997) "Developing partnerships in research: Päkehä researchers and Mäori research" Sites, 35(Spring):44–63.

Crengle, S. (2000). The development of Māori primary care services. Pacific Health Dialog. 7:48–53.

Cunningham, C., Stanley, F. (2003). "Indigenous by definition, experience, or world view" British Medical Journal, 327(7412):403–404.

Cunningham, C. (1999). 'Responsive research in Māori education', Palmerston North, Massey University.

Cunningham, C. (1994). A framework for addressing Māori knowledge in research, science and technology. In Te Pumanawa Hauora (9th Ed). Te Oru Rangahau Māori Research and Development Conference. Palmerston North: School of Māori Studies, Massey University.

Dalbeth, N., Gow, P. (2006). Alcohol excess may be overemphasised in gout treated in secondary care.NZ Med J. 119(1243).

Dalbeth, N., Kumar, S., Stamp, L., Gow, P. (2006). Dose adjustment of allopurinol according to creatinine clearance does not provide adequate control of hyperuricemia in patients with gout. J Rheumatol. 33:1646–50.

Davidson, B. (1993). The Black Man’s Burden: African and the curse of nation states East African, Publishing House, Nairobi.

Davis, P., Lay-Yee, R., Sinclair, O., Gribben, B. (1997). Māori/non-Māori patterns of contact, expressed morbidity and resource use in general practice: data from the Waikato Medical Care Survey 1991–2. N Z Med J, 110: 390–392.

Dewey, J (1974). John Dewey on Education: Selected Writings (R.D. Archambault, ed). University of Chicago Press: Chicago.

Dow, D.A. (1999). Māori Health and Government Policy 1840–1940. Wellington, New Zealand: Victoria University Press.

Durie, A.E. (1998a). 'Me tipu ake te pono: Mäori research, ethicality and development', *in* School of Mäori Studies (ed.), *Te Oru Rangahau Mäori Research and development Conference*, Palmerston North, Massey University.

Durie, A.E. (1993). 'Report on the evaluation of the 'Tihei Mauri Ora' teacher development contract', Palmerston North, Massey University.

Durie, M.H. (2004). Understanding Health and Illness: research at the interface between science and indigenous knowledge. International Journal of Epidemiology. Volume 33, Issue 5. 1138-1143.

Durie, M.H. (2000). 'Te Pae Mahutonga: a model for Mäori health promotion', Massey University, Unpublished manuscript.

Durie, M.H. (2000). Māori health: key determinants for the next twenty-five years. Pacific Health Dialog, 7 (1), 6_11.

Durie, M.H. (1998d). 'Strategic direction for Mäori research', *He Pukenga Körero*, 4, 1, 77-84.

Durie, M.H. (1998e). 'Te Oru Rangahau - concluding remarks', *in* Te Pümanawa Hauora (ed.), Te Oru Rangahau Mäori Research and Development Conference, Palmerston North, School of Mäori Studies, Massey University.

Durie, M.H. (1997). Māori Cultural Identity and the New Zealand search for nationhood. Published in the Australian and New Zealand Journal for Mental Health Nursing.

Durie, M.H. (1995). 'Matatini Mäori, diverse Mäori realities', Palmerston North, Massey University.

Durie, M.H. (1994a), The CHI model, a culturally appropriate auditing model - guidelines for public health services, Wellington, Public Health Commission.

Durie, M.H. (1994b). 'An introduction to the Hui Whakapümau', *Hui Whakapümau Mäori Development Conference*, Palmerston North, Department of Mäori Studies, Massey University.

Durie, M. A. (1985). A Māori Perspective of Health. Soc Science Med. 20:483–86.

Eachus, J., Williams, M., Chan, P. (1996). Deprivation and cause specific morbidity: evidence from the Somerset and Avon survey of health. BMJ, 312: 287–292.

Ellison-Loschmann, L, Pearce, N. (2006) Improving access to health care among New Zealand's Maori Population. Am. J. Public Health 96: 612–617.

Fricke, W. (2002). Action Research. Volume 1 (1): 9-28. Sage Publications, London.

Fortune, S., Watson, P., Robinson, E., Fleming, T., Merry, S., & Denny, S. (2010). Youth'07: The health and wellbeing of secondary school students in New Zealand: Suicide behaviours and mental health in 2001 and 2007. Auckland: The University of Auckland.

Gibson, T., Waterworth, R., Harfield, P. et al. (1984). Hyperuricaemia, gout and kidney function in New Zealand Māori men. Br J Rheumatol. 23:276–82.

Gilmore, T., Krantz, J., Ramirez, R. (1986). "Action Based Modes of Inquiry and the Host-Researcher Relationship." Consultation 5.3: 160-76.

Glover, M. (2002). Kaupapa Māori health research methodology: a literature review and commentary on the use of a kaupapa Māori approach within a doctoral study of Māori smoking cessation. Applied Behavioural Science, University of Auckland, Auckland, New Zealand.

Gow, P., Winnard, D. (2010) National Prevalence of Gout derived from administrative health data in New Zealand.

Gow, P., Sahid, H. (2005). Multidisciplinary care improves outcomes for patients with painful gout in South Auckland, New Zealand. Conference Proceedings 10th European Forum on Quality Improvement Care.

Gracey, M. (2007). Nutrition-related disorders in Indigenous Australians: how things have changed. The Medical Journal of Australia.186, 1, 15-17.

Graham, J. (2009). Na Rangi taua, na Tuanuku e takoto nei: Research methodology framed by whakapapa. MAI Review. 1 Article 3.

Green, L. W., George, A., Daniel, M., Frankish, C. J., Herbert, C. P., Bowie, W. R.(2003). Guidelines for participatory research in health promotion. In M. Minkler & N. Wallerstein (Eds.), Community based participatory research in health (pp. 419-428). San Francisco: Jossey-Bass.

Grennell, D., Cram, F. (2008). Evaluation of Amokura: An Indigenous family violence prevention strategy. MAI Review, 2, Article 4. Auckland.

Grey, A. (1997), 'Development practice and indigenous peoples', in Buchi, S., Erni, C., Jurt, L. and Ruegg, C. (eds.), Indigenous Peoples, Environment and Development Conference, Zurich, International Work Group for Indigenous Affairs, Department of Social Anthropology, University of Zurich.

Grey, G. (1953). Nga Mahi a Nga Tupuna. Māori purposes Fund Board. Wellington.
Hall A, Stewart R. Obesity (1989). Time for sanity and humanity. N Z Med J; 102:134–136.

Hall, Stuart. (19). Cultural identity and Diaspora. The Journal of Cinema & Media, Framework Journal, issue 36.

Harris, R., Purdie, G., Robson. B. (2007). Estimating Māori Hospitalisation and CancerRegistrations. In Robson B and Harris R (eds). Hauora: Ma ori Standards of Health IV. A study of the years 2000–2005. Wellington: Te Ropu Rangahau Hauora a Eru Po¯mare.

Hauora. T.P. (1998). A Research Paradigm. Paper presented at Māori Research & Development Conference Te Oru Rangahau.

Health Waikato. (2001). He Whakawhaititanga O Nga Ratonga Mate Huka: Integrated Diabetes project. A Cultural Stock-take of Health Waikato Diabestes Service. Investigating Preferences for Service Delivery.

Hemara, W. (2000). Maori Pedagogies: a view from the literature. A presentation to NZARE Conference, Te Whare Wananga O Waikato, Hamilton, New Zealand.

Hobgood, C., Weiner, B., tamayo-Sarver, J.H. (2006c). Medical error identification, disclosure and reporting: Do emergency medicine provider groups differ? Acad Emer Med. Vol. 13. 443-451.

Huang, H.Y., Appel, L.J., Choi, M.J., Gelber, A.C., Charleston, J., Norkus, E.P., Miller, E.R. (2005). The effects of vitamin C supplementation on serum concentrations of uric acid: results of a randomized controlled trial. Arthritis Rheumatology. 52.6. P.p. 1842-1847.

Hunn, J.K. (1961), Report on Department of Māori Affairs, appendix to the Journals of the House of Representatives, Wellington, Government Printer.

Hunter, D. (1956) 9th ed. In: Rose, B. Prior, I.A.M. & Davidson, F. (1968). In: Population Studies of the Rheumatic Diseases, Ed. P.H. Bennett & P.H.N Wood. Amsterdam. P. 344.

Isham, J., Narayan, D., Pritchett, L. (1995). Does participation improve performances? Establishing causality with subjective data. World Bank Economic Review, 9(2), 175-200.

Israel, B. (2003). Critical issues in developing and following community based participatory research principles. In: M. Minkler and N. Wallerstein, eds. Community-based participatory research for health. San Francisco, CA: Jossey-Bass, 53_76.

Israel, B. A., Eng, E., Schulz, A. J., & Parker, E. A. (2005). Methods in community-based participatory research for health. San Francisco:Jossey-Bass.

Iwikau. B. (2011). Kaitiakitanga as a Transformative Process of Learning for Whanau. Toroa-te-Nukuroa Volume VI, Whanau Transformation through Wananga Education. Te Wananga O Aotearoa.

Jackson, M. (1997). 'The nature of knowing: self-determination, land and the double helix', in Buchi, S., Erni, C., Jurt, L. and Ruegg, C. (eds.), Indigenous Peoples, Environment and Development Conference, Zurich, International Work Group for Indigenous Affairs, Jackson, M. (1996). "Mäori health research and Te Tiriti o Waitangi" in Hui Whakapiripiri: A Hui to Discuss Strategic Directions for Mäori Health Research, Te Röpu Rangahau Hauora a Eru Pömare, Wellington School of Medicine, Wellington.

Jasper, M. (2003). Beginning Reflective Practice (Foundations in Nursing and Health Care). Cheltenham: Nelson Thomas Ltd.

Jenkins, K., Pihama, L. (2001). "Matauranga Māori: Teaching Māori women's knowledge alongside feminism" Feminism and Psychology, 11(3)293–303.

Jewkes, R., Murcott, A. (1998). Community representatives:Representing the “community?” Social Science Medicine, 46(7), 843-858.

Jones, P. (2001). The modern management of gout. New Ethicals. 4:29–31.

Karangaoroa, M. R., Pihama, L. (2007). Matarakau nga korero mo nga rongoa o Taranaki. A report funded by the Foundation for research and science and Technology and the Health Research Council, NZ.

Kettilby, G., Tan, A.S., Berridge, M.V. (2000). Measuring respiratory burst. J Immunol Methods, 238**,** 59-68.

Kerr, S., Penney, L., Moewaka Barnes, H., McCreanor, T. (2003). Kaupapa Māori Action Research to improve heart disease services in Aotearoa, New Zealand Whariki Research Group, Massey University, Auckland, New Zealand. First published 16 December 2009.

Khanlou, N., Peter, E. (2005). Participatory action research: considerations for ethical review. Social Science & Medicine, 60, 2333_2340.

Kleinman, N.L., Brook, R.A., Patel, P.A., (2007). The impact of gout on work absence and productivity. Value Health. 10:231–7.

Klemp, P., Stansfield, S.A., Castle, B., Roberson, M.C. (1997). Gout is on the increase in New Zealand. Ann Rheum Dis. 56: 22-26.

Krieger N. (2001). A glossary for social epidemiology. Journal of Epidemiology & Community Health 55: 693 –700.

Krieger, N., Rowley, D.L., Herman, A.A., Avery, B., Phillips, M.T. (1993). Racism, sexism, and social class: implications for studies of health, disease, and wellbeing. American Journal of Preventive Medicine 9 (Suppl. 6): S82–122.

Krishnan, E., Baker, J.F., Furst, D.E., Schumacher, H.R. (2006). Gout and The Risk of Acute Myocardial Infarction. Arthritis Rheumatology. 54:2688-96.

Kumar, S., Gow, P. (2002). A Survey of indications, results and complications of surgery for tophaceous gout. NZ Med J. 115 (1158).

Lavoie, J. (2003). Indigenous Primary Health Care Services in Australia, Canada and New Zealand: Policy and Financing Issues. Winnipeg, Manitoba, Canada: Manitoba First Nations Centre for Aboriginal Health Research, University of Manitoba.

Lennane, G.A.Q., Rose, B.S., Isdale, I.C. (1960). Gout in the Maori. Ann Rheum Dis 19: 120-125.

Lewin, K. (1948). Action research and minority problems. In G. W. Lewin (Ed.), Resolving social conflicts (pp. 143-152). New York: Harper.

Lindsay, K. (2009). Grappling with gout in South Auckland. RACP News. Royal Australasian College of Physicians. P.9.

Loomis, T. (2000a). 'Government's role in Māori development: charting a new direction?' Hamilton, Waikato University.

Loomis, T. (2000b). 'Indigenous populations and sustainable development: building on indigenous approaches to holistic, self-determined development', World Development, 28, 5, 893-910.

Love, N. (1998). 'Māori development: the role of Te Puni Kokiri and the link to research', in Te Pumanawa Hauora (ed.), Te Oru Rangahau: Māori Research and Development Conference, Palmerston North, Massey University.

Malcolm, L. (1996). Inequities in access to and utilisation of primary medical care services for Māori and low income New Zealanders. NZ Med J, 109: 356-358.

Marsden, M., Henare, T.A. (1992), 'Kaitiakitanga, a definitive introduction to the holistic world view of the Māori', Unpublished manuscript.

McHugh, T.-L. F., & Kowalski, K. (2009). Lessons learned: Participatory action research with young Aboriginal women. Pimatisiwin: A Journal of Indigenous and Aboriginal Community Health, 7(1), 117-131.

McLoone, P., Boddy, F. (1994). Deprivation and mortality in Scotland, 1981 and 1991. BMJ, 309:1465–1470.

Mead, H. (2000). The Nature of Tikanga. Paper presented at Mai I Te Ata Haapara Conference, Te Wananga O Raukawa, Otaki. 11-13 August, 2000.

Metge, J. (2001). Māori Custom and Values in New Zealand Law. Tikanga encompasses both ways of doing things and the underlying values, that is, practices and principles, comments provided to the Law Commission on a draft, 16 February 2001:1.

Miller, R. L., Shinn, M. (2005). Learning from communities: Overcoming difficulties in dissemination of prevention and promotion efforts. American Journal of Community Psychology, 35(3/4), 169-183.

Moewaka Barnes, H. (2006). Transforming science: how our structures limit innovation. Social Policy Journal of New Zealand, 29, 1_16.

Moewaka Barnes, H. (2000). Kaupapa Māori: explaining the ordinary. Pacific Health Dialog, 7, 13_16.

Nairn, R., F., Pega, T., McCreanor, J., Barnes, A. (2006). "Media, racism and public health psychology" Journal of Health Psychology, 11(2):183–196.

National Cervical Screening Programme Independent Monitoring Group (NCSP IMG). (2007). Annual Monitoring Report 2004, National Cervical Screening Programme. Wellington: Massey University.

Narayan, D. (1992). The contribution of people's participation torural water supply: Findings from 122 projects. Washington, DC: World Bank.

Newman, A. K. (1880). "Transactions and Proceedings of the N.Z. Institute, 1879", vol. 12, p. 433.

Nuki, G., Simkin, P.A. (2006). A concise history of gout and hyperuricemia and their treatment. Arthritis Res Ther, 8 Suppl 1, S1.

Panelli, R., Gallagher, L., Kearns, R. (2006). Access to rural health services: research as community action and policy critique. Social Science & Medicine, 62, 1103_1114.

Parker, E., Margolis., L. H., Eng, E., Renriquez-Roldan, C. (2003). Assessing the capacity of health departments to engage in community-based participatory public health. American Journal of Public Health, 93(3), 472-476.

Pearce, N. (1996). Traditional epidemiology, modern epidemiology, and public health. Am J Public Health; 86: 678–683.

Pearce, N., Foliaki, S., Cunningham, C., Sporle, A. (2004). Genetics, race, ethnicity and health. BMJ, 328:1070–1072.

Pearce, N.E., Pomare, E.W., Marshall, S., Borman, B. (1992). Mortality and social class in Māori and non-Māori New Zealand men: changes between 1975–1977 and 1985–1987. N Z Med J, 106: 193–196.

Pearce, N.E., Davis, P.B., Smith, A.H., Foster, F.H. (1985). Social class, Ethnic group and male mortality in New Zealand 1974–78. J Epidemiology Community Health, 39:9–14.

Papps, E., Ramsden, I. (1996). Cultural safety in nursing: the New Zealand experience. Int J Qual Health Care, 8:491–497.

Pere, R. (1984), 'Te Oranga o te whanau: the health of the family, a paper presented at Hui Whakaoranga, Hoani Waititi Marae, 19-22 March 1984', Department of Health.

Pere, R. (1984). Ako: Concepts and Learning in the Māori Tradition, Hamilton: Monograph, Department of Sociology, University of Waikato.

Pihama, L. (1994) "Are films dangerous? A Mäori woman's perspective on The Piano" Hecate, 20(2):239.

Potaka, H. (1995). Flashback into the past, forward into the future address at 1994 Published in Play centre journal.

Puketapu, B.T.T. (2000). 'Māori organisation and contemporary Māori development', Māori Studies, Palmerston North, Massey.

Raelin, J. (2002). "I Don't Have Time to Think!" versus the Art of Reflective Practice. In Reflections, vol. 4, 1, 66-79, Society for Organizational Learning, Massachusetts Institute of Technology, Cambridge, MA.4

Ramsden, I. (2000). Cultural safety/kawa whakaruruhau ten years on: a personal overview. Nurs Praxis N Z. 15: 4–12.

Ramsden, I. (1994). The outcomes of colonisation for Māori people and Māori health status. Paper presented at: Māori Development Conference, August 1994, Palmerston North, New Zealand.

Reid, P., Robson, B., Jones, C. (2000). Disparities in health: common myths and uncommon truths. Pacific Health Dialogue 7: 38–48.

Rifkin, S. B., Muller, J., Bichmann, W. (1988). Primary health care: On measuring participation. Social Science and Medicine, 26, 931-940.

Ritchie, J (1963). The making of a Māori. NZ & P 378.95 V64p 15.

Robson, B., Harris, R. (eds). (2007). Hauora: Ma ori Standards of Health IV. A study of the years 2000–2005. Wellington: Te Roopu Rangahau Hauora a Eru Pomare.

Royal, C. (2003). Indigenous Worldviews – a comparative study. Wellington, Te Wananga o Raukawa.

Russell, K. (2004). Hui: A hui to discuss how to create and maintain a relationship with Māori organisations. Dunedin: Department of Community and Family Studies, University of Otago.

Sachdev, P.S. (1990). Behavioural factors affecting physical health of the New Zealand Maori. Soc Sci Med, 30: 431-440.

Salmond, C., Crampton, P., Lewis, S., Pearce, N. (1999). Asthma prevalence and deprivation: a small area analysis. J Epidemiology Community Health, 53:476–480.

Schwartz, S. A. (2006). Disease of distinction. Explore (NY), 2**,** 515-9.

Shaw, C., Atkinson, J., Blakely, T. (2004). (Mis)classification of ethnicity on the New Zealand Cancer Registry:1981–2004. New Zealand Medical Journal 122 (1294).

Shoen, C., Doty, M.M. (2004). Inequities in access to medical care in five countries: findings from the 2001 Commonwealth Fund International Policy Survey. Health Policy, 67:309–322.

Simon, J. (1993). State schooling for Maori: The control of access to knowledge. RUME Monograph, No 15, Auckland: RUME, University of Auckland.

Simon, J. (1992). European style schooling for Maori: The first century, *ACCESS*, 11, 31-43.

Simon, J. (1986). Ideology in the schooling of Maori children. *Delta Research Mongraph, 7.*

Simons, L.A., Simons, J. (1998), Diabetes and coronary heart disease. N Engl J Med. 339:1714.

Smith, A.H., Pearce, N.E. (1984). Determinants of differences in mortality between New Zealand Māoris and non-Māoris aged 15–64. N Z Med J, 97:101–108.

Smith, G. H. (2004). Mai Te Maramatanga, Ki Te Putanga Mai o Te Tehuritanga: From Conscientization to Transformation. In Educational Perspectives. Journal of the College of Education/University of Hawaii at Manoa. Volume 37 – No 1, 2004. Honolulu.

Smith, G., Smith, L. (1992), 'The issue of research and Mäori, monograph no. 9', Auckland, University of Auckland.

Smith, L. T. (2006). Researching in the margins: issues for Mâori researchers – A discussion paper. Alternative: An International Journal of Indigenous Peoples (2)1, 4–27.

Smith, L.T. (1996). Kaupapa Mäori Health Research. In Hui Whakapiripiri: A Hui to Discuss Strategic Directions for Mäori Health Research. Wellington School of Medicine: Te Röpü Rangahau Hauora a Eru Pömare. p.204

Smith, L.T. (1995). Towards Kaupapa Māori research. Māori University Teachers Conference, Massey University.

Smith, P. (1913). The Lore of the Whare-Wananga: or Teachings of the Māori College on Religion, Cosmogony and History , 2 vols, New Plymouth, Polynesian Society.

Singh, J.A., Reddy, S.G., Kundukulan. (2001). Risk factors for Gout and prevention: a systematic review of the Literature. PubMed. National Library of Medicine. 23 (20): 192-202.

Sorrenson, M.P.K. (1956). Land purchase methods and their effects on Māori population 1865–1901. J Polynesian Soc, 65:183–199.

Sporle, A., Pearce, N., Davis, P. (2002). Social class mortality differences in Māori and non-Māori men aged 15–64 during the last two decades. N Z Med J, 115: 127–131.

Sydenham, T. (1963). Tractatus de Podagra et Hydrope, London,

Tamihere, J. (1999). 'Changing whänau structures and practices', in Ministry of Health (ed.), Proceedings of Te Hua o te Whänau, Whänau Health and Development Conference, 16 April 1999, Conference held at Te Tütahi-ä-Toi, School of Mäori Studies, Massey University, Palmerston North, Ministry of Health.

Teariki, C.P., Spoonley, N. Tomoana. (1992) Te Whakapakari Te Mana Tangata: The Politics and Process of Research for Mäori, Department of Sociology, Massey University.

Te Ropu Rangahau Hauora a Eru Pomare. (2000). Counting for nothing: understanding the issues in monitoring disparities in health. Soc Policy J N Z.; 14:1–16.

Tsai, T. (2006). Nursing Partnerships in Indigenous Health. Advances in Contemporary Nurse Education, Nursing Journal, Volume 32/2 p.p. 264-266).

Vercoe, A.E. (1988). Educating Jake: Pathways to Empowerment. Auckland, HarperCollins.

Viswanathan, M., Ammerman, A., Eng, E., Gartlehner, G., Lohr, K. N.,Griffith, D. (2004). Community-based participatory research:Assessing the evidence (Summary, Evidence Report/Technology Assessment No. 99, AHRQ Publication 04-E022-1. Rockville, MD: Agency for Healthcare Research and Quality.

Wallace, K.L., Riedel, A.A., Joseph-Ridge, N., Wortmann, R. (2004). Increasing prevalence of gout and hyperuricemia over 10 years among older adults in a managed care population. J Rheumatol, 31**,** 1582-7.

Wallerstein, N., Duran, B., Aguilar, J., Belone Joe, L., Loretto, F.,Padilla, R., et al. (2003). Jemez Pueblo: Built and social-cultural environments and health within a rural American Indian community in the Southwest. American Journal of Public Health,93(9), 1517-1518.

Wallerstein, N., Duran, B., Minkler, M., & Foley, K. (2005). Developing and maintaining partnerships with communities. In B. Israel, E. Eng, A. Schulz, & E. Parker (Eds.), *Methods in community based participatory research methods* (pp. 31-51). San Francisco: Jossey-Bass.

Walker, R., Eketone, A., Gibbs, A. (2006). An exploration of Kaupapa Māori research, its principles, processes and applications. International Journal of Social Research Methodology, 9 (4), 331_344.

Webster, J., Walsh-Tapiata, W., Warren, T., Kiriona & Rangatahi Researchers. (2002). You say you've listened, but have you heard? Lessons learnt by pakeke and rangatahi researchers about research on rangatahi hauora. In Proceedings of the Indigenous Knowledges Conference Reconciling Academic Priorities with Indigenous Realities. Auckland. New Zealand: Ngâ Pae o te Mâramatanga.

Welch, D. (2006). Fatal Consequences. Listener. Saturday 27.5.06, 21-22.

Westbrook, I., Baxter, J., Hogan, J. (2001). Are Māori under-served for cardiac interventions? *N Z Med J,* 114: 484–487.

White, J. (1886-1890). The Ancient History of the Māori. Vol. 1-VI. Government Printer: Wellington.

Whitehead, M. (1992). The concepts and principles of equity and health. International Journal of Health Services 22: 429–445.

Williams, D.V. (1998). He Aha Te Tikanga Māori. Unpublished revised draft as at 10 November 1998 of Williams, 8.

Williams, J. (1998). He aha Te Tikanga Māori. Unpublished paper for the Law Commission. 9.

Willams, P., Gray, M., Ka'ai, T., Moorfield, J., Mcpherson, K., Weinstein, P., Nacey, J. (2003). Māori men's perceptions and experiences of health seeking for prostate health problems in New Zealand. Pacific Health Dialog VoL 10. No2.

Winnard, D., Kake, T., Gow, P., Barratt-Boyes, C., Harris, V., Hall, D., Mason, H., Merriman, T., Dalbeth, N. (2008). Debunking the muths to provide 21st Century Management of Gout. Paper written for The Maaori Gout Action Group in Counties Manukau District Health Board.NZMJ 23 May 2008, Vol 121 No 1274; ISSN 1175 8716

Appendices

Appendices One Pre-Post Whakamā Questionnaire

1. **What does Whakamā mean to you?**

____

____

____

a) **How would you rate your understanding of Whakamā?**

1	2	3	4	5
Limited understanding	Somewhat understanding	Good understanding	Very good understanding	Excellent understanding

b) Do you think Whakamā has contributed to you getting help through a health professional for gout?

(Please circle one)

1	2	3
Yes	No	Unsure

c) Do you think Whakamā has contributed to you not getting help through a health professional for gout?

(Please circle one)

1	2	3
Yes	No	Unsure

2. Do you think Whakamā has had an affect on you due to gout?

(Please circle one)

1	2	3	4	5
Limited affect	Somewhat affected me	Affected me to some degree	Affected me	Greatly affected me

a) Due to this affect, do you think Whakamā has contributed to you getting help through a health professional for gout?

(Please circle one)

1	2	3
Yes	No	Unsure

b) Due to this affect, do you think Whakamā has contributed to you not getting help through a health professional for gout?

(Please circle one)

1	2	3
Yes	No	Unsure

3 (a) As a result of how Whakamā has affected you, do you think whakamaa has contributed to you getting help through a health professional for gout?

(Please circle one)

1	2	3
Yes	No	Unsure

b) From your rating of how Whakamā has affected you, do you think whakamaa has contributed to you not getting help through a health professional for gout?

(Please circle one)

1	2	3
Yes	No	Unsure

Any further Comments

THANK YOU FOR YOUR PARTICIPATION

Appendice Two: Consent Form

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF FIVE (5) YEARS

I have read the Information Sheet and have had the details of study explained to me.
My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being audio taped.

I agree to participate in this study under conditions set out in the Information Sheet, but may withdraw my consent at any given time.

Signature: ____ Date: __________________

Full name – printed: ____

Appendices Three: Confidentiality Agreement

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF FIVE (5) YEARS

I ____(Full Name – printed) agree to keep confidential all information concerning the project

Signature: ____ Date: _________________

Full name – printed: ____

Appendices Four: Whanau (participants) Information Sheet

Researchers Information:	**Supervisors Information**
Betty-Lou Iwikau	**Te Tuhi Robust**
Service Manager	**Associate Professor**
021 576 721	**(09) 470 3555 Ext: 3760**
Employer Details:	**Employers Details**
Counties Manukau District Health Board	**Te Whare Wananga O Awanuiarangi**
Te Kaahui Ora Maaori Health	**Private Bag 9019**
Building 38B, Western Campus	**57 Raumanga Valley Road**
Private Bag 993311	**Whangarei 0148**
Otahuhu 1640	
Auckland	

Type and Purpose of Project

Have you ever experienced gout?
Do you know any of your whanau who has experienced gout?
Do you or your whanau understand the whakapapa about gout?
Would you like to come and share your knowledge about gout with others?
If you have answered yes to any of the above questions then this kaupapa requires needs your help.

This project is looking at developing a Te Ao Maori cultural framework model to help Maori whanau have a better understanding about gout and most importantly assist in developing a whakapapa model on Gout for all whaanau. We will have a korero first about the kaupapa before you consider whether you would like to participate. You will be asked to participate in a one-to-one interview with the researcher to share your experiences on living with gout, this will take about 2 hours or longer if you wish, the importance is you been able to share your story. I will also ask you to participant in four wananga-a-hui on a marae to assist in developing a whakapapa model about gout. You will be asked to consider four separate mornings. The times and dates will be discussed further with you if you agree you want to be part of this project.

Participant Recruitment

The flyer/poster advertised is an invitation to Maori whanau members registered in one of the following Maori Health Providers: Raukura Hauora O Tainui, Turuki Health Care and Papakura Marae Health Services. The number of participants for this project is targeted at 100 individual Maori; this figure could also be made up of Maori whanau as opposed to individuals. If you consent to participate, I will ask if you could put your personal details on forms, these details will not be identifiable to those outside this project, you will have a unique ID and in the writing of this project it would reflect this for all participants. You may choose not to answer some of the questions and you have the choice to withdraw from this project at anytime by

contacting the researcher. If you are a whaanau member on your own or a collective whaanau and would like support with you in the one to one interviews or the four wananga-a-hui we can work towards achieving this for you. The wananga-a-hui you will be asked to join other participants in this project to assist in developing a whakapapa model about gout. Kaumatua and kuia will also be part of this research to provide cultural guidance and support for us all and a list of support people in your area is provided also if you require them. Your experience and knowledge is very valuable and will be treated with the upmost respect, as your korero will be received as Taonga (gift).
Tikanga Maori (Maori protocols) will guide the process of engagement between me (the researcher) and 'YOU' and your whanau. 'YOU' will be fully informed of the process of this project every step of the way, the researcher receiving and holding of the korero, he taonga tenei (special gift). You will be provided with written information throughout this research and on going dialogue with the researcher. At anytime if you have any concerns about this research, please refer to the conflict resolution section of the information you will receive.

Project Procedures

The information collected in the one-to-one interviews and four wananga-a-hui will be used in the chapters of this thesis, for example a chapter in this thesis is on demystifying gout and demystifying whakamaa (inner consciousness, facial/body expressions). The information gathered in these two settings will assist immensely and towards the whakapapa model about gout. When the data is collected, the researcher will keep this information locked in a cabinet in her place of work, the only one who has the key is the researcher. All the information collected access to them will have electronic passwords, unique ID and keys. The researcher is governed by legislation to ensure the protection, holding of, receiving and storing this information through the Privacy Act 1993. Tikanga will also guide practices and processes in safeguarding this information used throughout this project. Tikanga will guide safe and inclusive processes and behaviours that encourage and develop cultural customs. This includes the use of consent forms, disclosure protocols and other such ethical safeguards. Tikanga is essential for safe implementation of Kaupapa Maori Research. The researcher will talk with you further on this kaupapa in the initial meeting. Once the information has been gathered and writing up, the researcher will then discuss with you whether you would like to receive a copy of the findings, whether you would like the information you have contributed returned to you. You do not have to make your decision at this time; we will discuss this further in our wananga-a-hui.

Participants' involvement

You will be asked to participate in a one-to one interview and four wananga-a-hui on a marae, times and dates will be confirmed if you agree to participate in this project.

Participants Rights

You have the right to:

- Decline to participate;
- Decline to answer any particular question;

- Withdraw from the study at anytime, the information that you have contributed to date, you will be asked if the information can remain
- Ask any questions about the study at any time during participation;
- Provide information on the understanding that your name will not be used unless you give permission to the researcher;
- To be given access to a summary of the project finding when it is concluded.

Taping:

- I also understand that I have the right to ask for the audio tape to be turned off at any time during the interview.

Support processes

- Kaumatua and kuia are available on request to provide support and guidance
- A list of support people in your area is provided also if you require them.

Project Contacts

- I f you have any questions about this project you can contact the researcher direct or her supervisor through the details provided at the top of this form.

Ethics Research Committee Approval Statement

- This project has been reviewed and approved by Te Whare Wānanga o Awanuiārangi Ethics Research Committee, ERCA # eg. 09/001. If you have any concerns about the conduct of this research, please contact the Chairperson of the Ethics Research Committee.

Contact Details for Ethics Research Committee chair

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Ethics Research Committee
Te Whare Wānanga o Awanuiārangi
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