

# Improving outcomes from pain management programmes in Aotearoa New Zealand: listening to the voices of Māori

David K Jones<sup>1</sup>, Rebecca M Mowat<sup>1</sup>, Gwyn N Lewis<sup>2</sup>   
and Catherine M Cook<sup>1</sup> 

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## Abstract

There are inequities for Māori (Indigenous peoples of New Zealand) in relation to chronic pain, including a disproportionate prevalence of chronic pain, a greater impact of pain, and reduced long-term benefit from chronic pain services. This likely arises from impacts of colonisation and racism within health services. The study aimed to determine the experience of Māori who had attended a 3-week pain management programme in Aotearoa New Zealand. Six participants were interviewed regarding their experiences of attending the programme, and the data analysed using thematic analysis. Five themes were developed: Lost and alienated, Manaakitanga (kindness, respect, care) created a supportive environment; Education enables mana āhua ake (personal autonomy); Whanaungatanga (relationship) is valued; and Where is the tikanga (Māori protocols)? The programme provided respectful care that facilitated participants to make their own health care choices. However, the lack of tikanga and Māori health views meant the programme was experienced as medical and Western-oriented.

## Keywords

chronic pain, cultural competency, equity, holistic care, Māori, pain management

## Introduction

Aotearoa New Zealand is made up of a diverse range of ethnicities. Māori (Indigenous peoples of New Zealand) are the tangata whenua (people of the land) and currently make up approximately 16% of the population (Stats NZ, 2019). Māori have been domiciled in what is now commonly called Aotearoa New Zealand for the last 800–1,000 years (Hurles et al., 2003) and were inherently robust and healthy people (Durie, 2012; Robson & Harris, 2007). However, the arrival of Europeans, ongoing colonisation, and failure to uphold Te Tiriti o Waitangi (Treaty of Waitangi), the founding agreement between Māori and the Crown, has had a devastating intergenerational impact on the health outcomes of Māori, including concerning chronic pain. Māori disproportionately experience chronic pain compared to non-Māori, Māori with chronic pain are more greatly impacted by pain (Lewis & Upsdell, 2018), and Māori do not benefit from chronic pain services in the long-term compared to people of European (Western) ethnicity for many clinical outcomes (Lewis & Bean, 2021; Mowat et al., 2022). Similar to many Indigenous cultures, Māori have a holistic view of health compared to Western biomedically-driven models (Reweti et al., 2023; Wilson et al., 2021). This worldview shapes experiences of pain and pain management, where Māori interpretations of pain

may incorporate spiritual, generational, and environmental aspects (Antunovich et al., 2024). Similarly, connections with people, cultural practices, the spiritual realm, and the land are seen as important for healing and are inherent within traditional healing practices (Hurles et al., 2003). However, these interpretations of pain and healing practices are not overtly incorporated into Western-based pain management practices.

Systematic reviews and meta-analyses indicate that multidisciplinary programmes are the gold standard for managing chronic, non-malignant pain (Becker, 2012; Guzman et al., 2001; Scascighini et al., 2008). However, the outcomes are modest overall as not everyone benefits to the same extent from these programmes. While there is a dearth of high-quality evidence regarding factors that predict outcomes from pain management programmes, a systematic

<sup>1</sup>Department of Nursing, Auckland University of Technology, New Zealand

<sup>2</sup>Department of Physiotherapy, Auckland University of Technology, New Zealand

## Corresponding author:

Gwyn N Lewis, Department of Physiotherapy, Auckland University of Technology, Private Bag 92006, Auckland 1142, New Zealand.  
Email: gwyn.lewis@aut.ac.nz

review found that, similar to the Aotearoa New Zealand data, non-Western people who attend Western-based programmes do not benefit to the same extent as those from Western cultures (Brady et al., 2016). Qualitative research has indicated that poor communication from clinicians, Western-based health models, and a lack of incorporation of spirituality contribute to inadequate pain management interactions with culturally diverse populations (Brady et al., 2017; Lin et al., 2018; Yoshikawa et al., 2020). Given these findings and the evident inequities in outcome from pain services in Aotearoa New Zealand, the goal of the current study was to determine the experiences of Māori who had attended a 3-week pain management programme located in a provincial city in Aotearoa New Zealand. Specifically, we were interested in their experience of the programme through a Māori lens and any recommendations they had for the programme that would address their unique cultural needs more appropriately.

## Methods

The project was undertaken in a partnership between Māori and non-Māori where participants were seen as expert advisors in their own lives, and participant's stories were held, supported, and respectfully analysed using a Māori-centred research design (Hudson et al., 2011). An interpretive descriptive methodology was chosen to provide a deeper understanding of the data and the participants' experiences. Prior to fully developing the study, consultation was undertaken with a Mātauranga Māori Committee at the authors' institution, who provide feedback and advice to support researchers to undertake culturally responsive research that benefits whānau Māori (Māori families). Consultation was also undertaken with Te Kāhui Māori (The Māori Advisory Committee) at QE Health, the clinical centre involved in the study. Te Kāhui Māori provided ongoing input and support during the design, ethical approval, data collection, and data interpretation phases of the project. The data obtained from the participants has been returned to Te Kāhui Māori so it remains in Māori ownership.

The authors are Māori—Author 1, and Pākehā (New Zealanders of British European descent)—Authors 2, 3, and 4, health researchers and health providers who are committed to upholding the principle of Te Tiriti o Waitangi to promote equity for Māori. Author 1 is descended from Waikato Rereahu-Maniapoto (a Māori tribe, Waikato-Waitomo, North Island, New Zealand) and is a rongoā Māori (traditional Māori treatment) practitioner who has connections to the local community. He has extensive knowledge in tikanga (Māori protocols) and mātauranga Māori. Author 2 is a nurse and osteopath who had an existing research relationship with the clinical centre where the pain management programme is based. Author 3 has a background in pain research, including projects identifying inequities in chronic pain in Aotearoa New Zealand and qualitative studies investigating different cultural interpretations of pain. Author 4 is a nursing researcher who has partnered with Māori investigators in multiple health research projects.

The clinical centre is located in an urban area where Māori make up 37.5% of the population. It is an area of marked cultural significance for the local iwi (tribe) and is well-known for its geothermal features and activity. The clinic has a holistic approach to wellness that integrates Western-based science with natural therapies. It includes a multidisciplinary team that focus on restoring physical, mental, and spiritual well-being. The 3-week pain management programme runs on weekdays, 8 hours a day, with people normally boarding at the facility during the week and leaving in the weekends. Attendance at the programme can be self-funded (private) or government-funded through referral from a general practitioner or specialist. The programme content is predominantly delivered through small group (4–6 people) discussions and involves a multidisciplinary team of clinicians. There are a range of treatment modalities offered, including physiotherapy, aquatic exercise, circuit exercise, mindfulness, education, massage, vocational planning, sleep hygiene, graded exposure, and goal setting. The overarching delivery approach is based on a biopsychosocial model (Gatchel et al., 2014).

## Participants

The inclusion criteria for participants were attendance at the 3-week pain management programme within the last 5 years, self-identification as Māori, and aged over 18 years. Recruitment was assisted by Te Kāhui Māori, who made the initial approach to potential participants through a phone call to provide information on the study and its kaupapa (purpose, ideology). Six people (aged 55–70, five women, one man) were informed about the study and all agreed to participate. All participants had attended the programme through a government-funded referral.

Ethical approval was obtained through the Auckland University of Technology Ethics Committee (#22-186) with locality approval from the clinical centre. All participants provided verbal and written consent.

## Procedure

Individual semi-structured interviews were held between the participants and the lead researcher at a location of the participant's choosing. Participants were invited to bring whānau (extended family members) or support people to the interview; one of the participants was supported by their partner who also contributed to the interview. Cultural rituals were incorporated into the interview process (Lacey et al., 2011). Interviews were opened and closed with karakia (prayer) and kai (food) was provided by the researcher. Whakawhanaungatanga (relationship building) was instigated through initial phone calls between the lead researcher and the participants to establish connections, and general conversation at the beginning of the interview. Following the general conversation, the interviews ranged from 15 to 60 min in duration. One participant provided an additional audio recording to the lead researcher that contained further thoughts she had following the completion of her interview. All interviews were audio recorded and transcribed verbatim, including the additional recording.

## Data analysis

Reflexive thematic analysis was used to analyse the interview data as it is effective for constructing themes and patterns in large data sets (Braun & Clarke, 2022). The analysis involved six iterative and recursive phases. In the first data familiarisation phase, all the transcripts were read by all of the authors. The second phase consisted of coding the transcripts, which was undertaken by three of the authors. From these codes, prototype themes were constructed independently by the three authors and then discussed together as a whole team, which revealed considerable overlap of the prototype themes. During these discussions, the lead author provided a holistic interpretation of the interviews in the greater context of the participants' lives, enabling meaningful discussion around the participants' stories. The fourth phase consisted of reviewing and further developing and discussing the themes as a team. During this phase, the prototype themes were presented to Te Kāhui Māori at a face-to-face hui (meeting) to obtain their feedback. Participants were also sent a written summary of the findings, recommendations, and future plans. Following these steps, there was further refining and naming of the themes before the final phase of writing up the findings and selecting relevant quotes. Participants were given the opportunity to come up with their own pseudonym for use in published material.

## Results

Five themes were developed from the data and are described below.

### *Lost and alienated*

Participants gave numerous examples of where they had grappled to engage with mainstream health care services that were perceived to be uncaring, inaccessible, and fragmented. Unsurprisingly, most participants indicated that they were not coping with their pain prior to involvement in the programme. The profound impact of pain was evident in descriptions of the "mental anguish" (Copper, 70, female) of pain and that "all I could do was cry" (Puretu, female, 69). This global distress was particularly evident for Rongoā:

I was depressed, I was overweight. I didn't know whether I was coming or going. My medication was all to hell. My job kept me sane. I wasn't suicidal, but I was bloody near it. (Rongoā, female, 69)

Previous negative experiences with the health care system seemed to contribute to the overwhelming nature of pain. Most participants recounted that medical staff, particularly specialists, had been unable to form meaningful relationships with them. Participants reported that they often saw multiple doctors and felt the appointments were rushed, meaning there was no time for introductions or to get to know each other. One participant commented that their specialist "never really talked to me" and that "He

didn't even introduce himself. Just, hello, I've looked at your notes. You need to go home and meditate" (Rongoā, female, 69). Some participants also felt they did not get sufficient information about their condition or received different opinions from different doctors. Others expressed experiences of racism. The partner of Copper, who attended as a support person, described the apparent imposition of racialised assumptions:

They'd say to [partner], "do you drink?" And she'd go, "no." And then they'd wait until she wasn't there and then they'd go to me, "oh, how much does she drink?" Well, no, she doesn't. She's not a drinker. I felt sometimes that was quite racist. It was almost as if, "you are Māori so you must drink a lot." That really annoyed me. (partner of Copper)

Others felt that being Māori made it difficult to engage with and navigate through the health system. One participant described, "I was lost, and I was lost in a system at the hospital that didn't care" (Rongoā, female, 69). Participants expressed frustration at cancelled appointments, chasing referrals, and a lack of knowledge about the pain management programme at the clinic. Some of the participants lived in difficult social circumstances that made accessing health care challenging, such as unreliable mobile coverage, and most were reliant on whānau for transport and support.

### *Manaakitanga created a supportive environment*

This theme centred on the perceptions of the caring and supportive nature of staff at the clinic, and the contrast this made with the previous negative experiences of mainstream health care. At the clinic, staff were viewed as caring, supportive, patient, and reassuring. Participants highly valued these characteristics and most expressed multiple positive comments about the staff. As one participant stated, "I can't compliment them enough. I really can't compliment them enough" (Mrs W, female, 55). It appeared that the extra time with clinicians on the programme contributed to positive interactions:

This little man, my specialist, that had a little bow tie and he was so lovely because he was so excited to see you and he made you so welcome and you weren't rushed out of his office. He talked to you like he wanted to help you and he talked to you like you were a person. (Rongoā, female, 69)

The extended time and the small class size appeared to facilitate the formation of meaningful relationships with clinicians. However, it was not only the clinical staff who made a difference. Participants expressed that being made to feel welcome was highly valued, no matter who that came from. Rongoā (female, 69) indicated that "It was about who was there at the door to greet me when I went in and to say goodbye to me when I left." These efforts to welcome and support participants meant they felt like they were looked after and were reassured there would always be someone there for them:

Oh, it was just the way that they talked to you. They didn't talk down to you, you know, and if you had any problems, you knew you could go to them. You know, so they were good. (Mrs P, female, 65)

These experiences highlight the importance participants placed on *manaakitanga* (kindness, respect, care). This clearly contrasted with previous interactions with clinicians the participants had experienced. The ability to form a connection with staff was interpreted positively by the participants and made it feel like they were being treated as a person, while the support and reassurance provided by staff seemed to make it a safe environment where the participants could challenge themselves and participate more fully in the programme.

### *Education enables mana āhua ake (personal autonomy)*

This theme highlights the reported value of the educational aspects of the programme and how the increased knowledge enabled participants to accept and self-manage their pain better. The ability to make one's own choices facilitates personal autonomy and the maintenance of unique identity. Despite many previous health care encounters, some participants expressed limited knowledge about their condition or treatment options prior to attending the programme. By contrast, participants spoke positively about the education component of the programme. The information presented was described as helpful for understanding how their body works and their condition, as well as providing a better idea of ways to manage their pain and how treatments work. For example, Rongoā (female, 69) stated, "That was the beginning of me starting to realise that I wasn't going crazy, that there was something wrong, and that they could do something about it." This quote highlights the inter-relationship between participants' mental well-being and appropriately provided information about their condition. Participants appeared to value the education because of the way that it was delivered. They indicated that information was simple and presented in a format that was understandable and made sense for them:

People on the education programmes, they simplified it so that you can understand. Because we were all old, you know, and none of us know these big words, but they simplified them so that it was understandable. Everything was beautiful. I understood everything they said. (Mrs W, female 55)

The above quote draws attention to the importance of health professionals packaging education appropriately for specific audiences. The information provided to participants enabled them to identify what brought on their pain and gave them other options for management. This increased knowledge was equated with power, and it appeared to facilitate participants' acceptance of their pain and their ability to make informed choices about how they managed it. Copper (female, 70) indicated that, "If I've got the tools to deal with it, I can do something about it" while Mrs W (female, 55) stated, "It's amazing what you can do when

you're taught." Being able to self-manage their pain gave the participants a greater sense of control and meant they were less reliant on medication for pain management:

At the beginning of it, I was like I need something, I haven't got anything. I have to have drugs. It's horrible. But now I understand at this end that I've got that as a backup . . . . Being in control of what I can do is really a big thing. (Copper, female, 70)

The participant went on to detail the nuanced way they were able to investigate their pain experiences, analysing the antecedents and quality of the pain and exemplifying of some of the transformative experiences participants had as part of participating in the programme (Copper, female, 70). Most participants clearly expressed a desire to self-manage their condition and make their own choices about how they managed it, and being in control was highly valued.

In conjunction with the increase in knowledge the programme provided, all participants indicated that the right attitude was needed to be successful and to gain benefit from the programme. Determination, perseverance, and self-belief were all described as requirements during the programme and afterwards. This is evident in Rongoā's (female, 69) *kōrero* (talk):

They have physiotherapists and guys there that want to spend the time with you. So, if you want some goodness out of what they're giving you, then you've got to be prepared to be there 150%. Doesn't matter how hard it is and how sore it is, because at the end of it, you feel so much better.

The determination of some participants to complete the programme appeared to be motivated by their own goals, such as, "I've got a new granddaughter and I want to see her grow up and get married. That's a driver for me as my grandchildren grow up" (Tane, male, 67). This committed attitude was also evident in that most participants said that they kept up some of the programme activities at home.

### *Whanaungatanga is valued*

This theme provides evidence that *whanaungatanga* with other patients and with the clinic were also highly valued. Participation on the programme made the participants feel like they were part of something, and they benefitted from the support of and interaction with others. This beneficial social aspect is evident in Mrs W's (female, 55) statement:

I think it was more around being with other people . . . . Mixing and mingling with others, the social aspect of things. There was about four of us in our group that were all on our own, that were quite lonely. So when we got together with each other, we would talk as if there was no tomorrow. It's only because you have no one else to talk to you at home.

The small group format seemed to afford meaningful social interaction that was still considered to be on a personal level. The participants clearly valued having other people with similar chronic pain conditions and life experiences to

talk to. The importance of social connection on the programme was evident in Copper's (female, 70) comment that, "When you get home, you get out of that little supported bubble environment." The relationships formed on the programme therefore played a supportive role rather than just providing an avenue for social interaction.

The participants additionally appeared to value their relationship with the clinic. When questioned about whether they would like to return to the clinic to repeat the programme or do a refresher course, almost all participants responded positively, "Oh yes, of course I do. Yes, I do" (Puretu, female, 69). This desire, for some, appeared to be motivated by maintaining a connection with the clinic and connecting with staff again. Copper (female, 70) continued her relationship with the clinic through regular phone calls to ensure that she stayed within their system, and made a further suggestion of staging the programme over time (rather than a block course) to provide ongoing contact. Therefore, the social interaction with others and connections that were formed with the clinic were highly valued.

### *Where is the tikanga?*

This theme focused on the participants' desire to have more te ao Māori (Māori worldview) content within the programme. When probed, almost all participants commented about an absence of tikanga and te ao Māori within the programme. The significant gaps identified included the lack of te reo Māori (Māori language), karakia, rongoā Māori, Māori understandings of health, and Māori staff. These omissions meant participants viewed the programme as Western-oriented: "It was caringly done, but it was very medically focused" (Copper, female, 70). Some participants expressed surprise at the lack of simple protocols like karakia, and they spoke of different solutions they had used to incorporate their own karakia within the day while at the clinic. The following participant emphasised the importance of what karakia signified:

And so, when you're eating kai, you know there's a karakia for kai. So you're brought down into that space, or brought into that space. You are there for specific reasons. So, your kai stays there. You go out and do your mahi [work]. You karakia at the start you karakia to finish, and it gets you into that mindset for the rest of your healing. And at the end of it, even if you are swimming or whatever, it just means that you are fully rounded and supported, rather than just doing a programme as you're going through. (Copper, female, 70)

Thus, the absence of tikanga impacted the participants' ability to fully immerse in the programme in a culturally supported way. A couple of participants noted a preference for inclusion of rongoā Māori treatment rather than Western equivalents, with Rongoā (female, 69) explaining, "I would've liked to have had massages, but I would've liked to have gone to have a proper mirimiri [traditional Māori massage] where there was karakia." Some participants commented that more Māori staff or the presence of a kaumātua (Māori elder) would have facilitated more kōrero: "But if I was talking to Māori, I'd be more open with what

I want to talk about" (Mrs W, female, 55) and "There weren't any Māori staff. And so, when you are feeling like you don't want to talk, it's not because you don't want to talk. It's because you're not that way inclined to tell everyone everything" (Copper, female, 70).

It was apparent that some of the participants limited both their clinical and casual conversations while on the programme. Participants identified that stronger connections would have been generated if there were Māori staff as relationships of trust would have more readily been fostered, leading to more open dialogue.

The participants also expressed a need for more genuine engaged kaupapa and described a tokenistic inclusion of a Māori health model within the programme. The partner of one of the participants outlined a process of converting the programme learnings into a Māori framework to implement the knowledge, and several participants identified their own interpretations of their pain and preferences for treatments that do not align with biomedical models. The desire for a more holistic programme that incorporated te ao Māori was evident:

All of those intricacies come into your way of healing and being. All of that sort of thing. So, mindfulness, you know, there's no relatability to spirituality, wairua [spirit], to how are you feeling? How's your wairua? I think if that would've been there, it would've meant you're not so clinically based. You are more holistically based. (Copper, female, 70)

Hence, while the programme was universally spoken of positively, the participants clearly noted there were aspects of te ao Māori that were missing that would have made the programme align better with their worldview. In support of this immersive approach, almost all of the participants expressed support for the potential of a Māori-only programme. Participants spoke of the benefits of shared understandings between Māori and the incorporation of te ao Māori, "But for some who are extremely shy and who only have their whānau who are Māori, I think that the specific Māori flavour, or whatever they call it, should be addressed" (Rongoā, female, 69).

While the participants found the programme enjoyable and beneficial, it did not appear to meet the cultural needs for many of them and they perceived there would have been further benefits if the programme had aligned more with te ao Māori.

## **Discussion**

This is one of the first studies to focus the experience of Māori who have attended a mainstream chronic pain management programme. The themes identified indicate that, despite previous poor experiences from health care services, participants clearly had an overall positive view of the mainstream programme. They felt cared for and supported, and valued the educational aspects of the programme that facilitated their understanding of their condition and ability to self-manage. Whanaungatanga, and other relational and social aspects of the programme, were also highly regarded. However, despite these positive

views, the cultural needs of the participants were not fully met, and there were numerous instances where the lack of te ao Māori potentially limited the therapeutic value of the programme.

Racism and negative experiences from health care are well documented for Māori in Aotearoa New Zealand (Cormack et al., 2018; Graham & Masters-Awatere, 2020; Wepa & Wilson, 2019; Wilson & Barton, 2012) as well as in other Indigenous populations internationally (Arambula Solomon et al., 2022; Boyer, 2017; Kairuz et al., 2021). Our findings of difficulty navigating the health system, mistrust, and poor relationships with clinicians also align more specifically with experiences of Indigenous or culturally and linguistically diverse groups in the management of chronic pain (Bernardes et al., 2022; Clarke et al., 2022; Sloots et al., 2010; Yoshikawa et al., 2020). The poor provision of care and historical privilege of Pākehā in our health system (Borell et al., 2018) likely contributes to the greater burden of pain and reduced benefit from treatment for Māori. The inherited power of Pākehā resulted in the creation of a health system that provides structural advantages for Pākehā and privileges Western models of care and views of well-being. The historical inflexibility of such systems to incorporate te ao Māori is likely a strong driver of the health inequities Māori face.

These negative experiences contrasted with the participants' views of the current pain management programme. Manaakitanga is central to Māori values, including those related to health (Wilson et al., 2021). The respectful and kind nature of care provided by the clinic staff appeared to facilitate whakawhanaungatanga and provided a more trusting and supportive space, and likely created an environment that raised the potential for better outcomes. The therapeutic alliance is known to be influential in outcomes for people with chronic pain conditions (Farin et al., 2013; Ferreira et al., 2013; Fuentes et al., 2014; Kaptchuk et al., 2008), and whanaungatanga is particularly important to and valued by Māori, including in relation to health (Wilson et al., 2021). For example, previous work has highlighted the responsibility of health care professionals to build and maintain whanaungatanga with Māori patients, which has been shown to facilitate gains in health literacy and enhance self-management practices (Carlson et al., 2019). The importance of relationships was also evident in our study in the value the participants placed on the social and relational aspects of attending the programme, including connections made with other patients, clinic staff, and the clinic itself. The extended time afforded through the 3-week programme likely facilitated the formation of these relationships, as well as providing time for reflecting on the information presented. Indeed, whakawhanaungatanga in health care requires time to establish connections and bonds, and time for both clinicians and patients to share aspects of themselves (Wilson et al., 2021). Most of the participants in the current study stated that they would like to return to the clinic if they had the opportunity, showing a desire for the ongoing maintenance and growth of these relationships.

Tino rangatiratanga (self-determination) in terms of the right to options is one of the key principles of Te Tiriti o Waitangi (Waitangi Tribunal, 2023) and active involvement in health care decisions is valued by Māori (Kirkcaldy, 2023). Self-management is also a common goal of chronic pain management programmes (Turk & Okifuji, 1998). To achieve this, patients need adequate information to be able to make informed choices about their health care. The participants in the current study indicated that the education they were provided and the way it was delivered enabled better understanding of their health and provided alternative ways of managing pain. This follows previous research showing that pain science education can be effective in enhancing patient outcomes, particularly when provided alongside other therapy (Moseley et al., 2023), and it is an integral component of most pain management programmes (Lewis et al., 2019). It was evident that the information provided does not have to be complex to be effective, suggesting that a mode of delivery that enables patients to acquire new knowledge may be more important (Chimenti et al., 2023). Our study highlighted the importance of clinicians tailoring education to the patient. The presence or absence of this relational aspect of education was vivid for participants in the current study. Where they felt seen and heard, they were far more likely to persist with clinicians' recommendations for an extended period post-discharge.

It was noteworthy that all participants talked positively about their experience of the clinic; however, when specifically questioned about te ao Māori content, almost all participants raised limitations and issues that indicated the programme did not meet their cultural needs. Importantly, this is likely to have impacted on their outcomes. These findings also need to be taken in context of the clinic's location in an area with a relatively large Māori population that is also well-known for its natural features, many of which are taonga (treasured) for the local iwi. These limitations perhaps reflect the strong colonial history of the clinic, originally serving as a rehabilitation centre for soldiers returning from World War II, and the strictly biopsychosocial nature of the programme. In the current study, the perceived benefits of incorporating more cultural aspects within the clinic and programme were apparent. These included a stronger sense of connection and trust with Māori staff that would enable deeper conversations and understandings, incorporation of tikanga that would help to maintain and enhance wairua (spirituality), and the holistic nature of traditional treatments that would align better with interpretations of pain and views of health and well-being by Māori. The inclusion of or access to traditional treatments for pain is important for Indigenous and migrant populations who reside in Western-based societies. In Indian and Chinese cultures, it has been shown that access to such treatments provides hope, strengthens cultural identity, and addresses aspects of spiritual, relational, or environmental health that are not incorporated in Western-based treatments (Kwok & Bhuvanakrishna, 2014; Lewis et al., 2023). It has also been described previously in studies based in Taiwan (L. Chang, 2005; H.-Y. Chang et al., 2021) and rural India (Pati et al.,

2019) that people use a mixture of Western and traditional practices depending on the interpretation of their pain and access to services. Enabling such blended choices provides patients with the potential to benefit from both approaches.

### Recommendations for clinical practice

Our recommendations for the clinical centre are derived from the themes just presented, encompassing concepts of manaakitanga, whanaungatanga, mana āhua ake, and tikanga. The recommendations include those that are directed at the individual clinician level that could be implemented fairly quickly, followed by those at a more programme and clinic level. Feedback from Te Kāhui Māori has also been incorporated within the suggestions (Table 1).

**Table 1.** Recommendations for clinical practice separated into those that can be implemented in the short- and long-term.

Short-term	Long-term
Treat patients with manaakitanga (care, respect)	Incorporate rongoā Māori (traditional Māori (Indigenous peoples of New Zealand) treatment)
Take an interest in a patient's whakapapa (genealogy) and share aspects of yourself	Include more Māori staff
Be accepting of patients' knowledge and beliefs about pain	Develop a programme for Māori patients only
Provide a cultural navigator for each intake	Provide improved transport that works with the programme hours
Incorporate elements of Te Whare Tapa Whā (a Māori model of health and well-being) into the programme, for example, education and discussions around social and spiritual well-being	Provide onsite accommodation on an equity basis
Include pōwhiri (welcome ceremony), te reo Māori (Māori language), karakia (prayer), waiata (songs), and traditional stories or history relating to the local area	Deliver the programme, or parts of it, in the community
Provide cultural competency training for staff	Have ongoing communication with patients after completion of the programme
Include sessions on health system navigation	Establish networks or support groups of former patients

Manaakitanga had a positive impact, and the clinic currently is doing this well. Health care providers should treat people with respect, kindness, generosity, empathy, and compassion. They should make time to establish relationships, including taking genuine interest in the whakapapa (genealogy) of the person and sharing relevant

aspects of themselves. Health care providers should be non-judgemental and accepting of patients' knowledge and beliefs about their pain, and provide encouragement and support throughout clinical interactions. These factors are likely to support whakawhangaungatanga and enhance mana (prestige, power; Kirkcaldy, 2023).

The pain management programme should provide education about and overtly incorporate Te Whare Tapa Whā (name of a Māori model of health and well-being; Durie, 1985) and rongoā Māori as well as Western views of health and treatments. Incorporation of these models and practices would enable patients more choice about treatments and options that align with their cultural strengths. Ideally, this would be delivered in a way that enables multiple concepts or understandings of pain to be possible to enable patients to make choices and have an active involvement in their health care (Moseley et al., 2023). Whare Tapa Whā (Durie, 1985) is simple and commonly recognised in Aotearoa New Zealand, and its holistic view of well-being is common across many non-Western cultures (Loving, 2012; Mao et al., 2021; Pandav & Kumar, 2018; Pulu-Endemann, 2001). Rongoā Māori is an integrated treatment approach that incorporates elements of wairua, tinana (body), whenua (land), tikanga, rākau (plants), and whānau (Marques et al., 2021). The current clinic is an ideal space for on-site incorporation of rongoā Māori given its location and resources. For programmes in other locations, establishing relationships with local providers may be a more appropriate option. Incorporation of tikanga is also paramount, including use of pōwhiri (welcome ceremony), te reo Māori, karakia, and waiata (songs). In addition, inclusion of the history or traditional stories about the local area, for example, in relation to the natural resources that are used at the current clinic, would provide greater understanding of the meaning and importance of te taiao (the environment) where the programme is situated.

We think it would be important to give people the choice of a programme that is only for Māori. While the programme may still be centred in a Western context, having exclusive Māori participation would likely promote stronger connections between patients and a safer cultural environment. To facilitate the implementation of these suggestions, we additionally recommend that staff undertake cultural competency training. Together, these factors would more comprehensively address all elements of health for Māori and promote a better environment for healing and restoring well-being (Kirkcaldy, 2023).

We also recommend some structural changes to how the programme is delivered. Given the participants' previous experiences of feeling lost and alienated in other health care settings, cultural navigators for each intake and the addition of more Māori staff is suggested. These do not need to be clinical staff, but someone for patients to connect with more easily and meaningfully. In addition, the incorporation of advocates for or sessions on health system navigation may be useful. As many of the participants were reliant on whānau to attend the programme and other health care appointments, we recommend improved access to

transport for patients or providing more equitable access to the onsite accommodation available. The clinic could additionally consider ways the programme content could be delivered in the community at locations that are more familiar and accessible to whānau Māori. Finally, we recommend that the programme incorporates ongoing sessions and communication with patients to maintain the relationship with the clinic and with others who have attended the programme. Connections with other relevant groups in the local community could also be promoted. Maintaining such connections is an important aspect of whanaungatanga that shows the ongoing nature of the relationship.

### Strengths and limitations

The project was undertaken in collaboration with Te Kāhui Māori and with a clinical centre the authors had a long-standing relationship with. This facilitated the recruitment of participants and ensured the project remained beneficial to Māori and with Māori oversight. There were also some limitations. As a small project, we included only six participants. However, the depth of the interviews enabled meaningful themes to be constructed. Three of the authors are Pākehā and a Western approach to methodology, methods, analysis, and write-up was undertaken. Thus, the project is Māori-centred rather than a kaupapa Māori (Māori approach) methodology. However, we have aimed to incorporate as many principles of kaupapa Māori into the project as possible. This includes producing a tangible outcome for the clinic and whānau Māori, maintenance of data sovereignty with Te Kāhui Māori Committee, and a commitment to an ongoing relationship with the clinic that will aim to further promote improved outcomes for Māori with chronic pain in the local community through continuing research partnerships.

### Conclusions

The findings highlight many previous negative experiences of health care for Māori with chronic pain. In contrast, the current clinic provided a caring, supportive environment that enabled Māori to enhance their knowledge about managing their condition and form meaningful relationships with clinic staff and fellow patients. Despite these positive aspects, many aspects of te ao Māori and tikanga were missing from the programme that would have promoted a more holistic approach to rehabilitation and well-being.

### Authors' note

**David K Jones** (Waikato Rereahu-Maniapoto) (MA) is a rongoā practitioner and a multidisciplinary lecturer in Te Tari Mātauranga Māori (Māori Studies Department) at Te Whare Takiura o Manuka (Manukau Institute of Technology), as well as a member of the Unitec Research Ethics Committee. His research interests lie in Māori health ecology and he has a strong background in education, earth science, health science and information science working for organisations and institutions such as Te Whare Wānanga o Awanuiārangi, Te Wānanga o Aotearoa, Te Wānanga o Raukawa,

Te Toi Ohomai, Waikato University, and Auckland University of Technology. David was an advisor to ACC which saw the introduction of rongoā Māori as a therapeutic option, developed and delivered many of the country's rongoā qualifications and programmes, and works to decolonise health education and instruction while continuing to assist iwi, hapū and whānau with their health aspirations.

**Rebecca M Mowat** (DHSc) is a Senior Lecturer working in the Department of Nursing at Auckland University of Technology. She has been working in health industry for more than 30 years and has a passion for understanding how to improve care and management of those who have chronic pain and an interest in older adult health. Rebecca identifies as Pākehā and is a seventh generation New Zealander—her French ancestors were some of the first Pākehā to arrive in Aotearoa on the Comte de Paris, in 1840.

**Gwyn N Lewis** (PhD) is a Pākehā health researcher in the Department of Physiotherapy at Auckland University of Technology. She obtained a PhD in 2003, and her research background is in motor control and neurophysiology. For the last 10 years, Gwyn's focus has been on pain research, with projects centring on cultural interpretation of pain, promoting equity in pain management, predicting outcomes from treatment, and understanding the neurophysiology of the pain system.

**Catherine M Cook** (PhD) identifies as tauīwi, born in England of Scottish and Irish descent. She is an Associate Professor in the School of Clinical Sciences at Auckland University of Technology. Catherine's clinical background is in nursing, midwifery, and counselling. For many years, she has had clinical and research interests in the health workforce, sexuality, sexual health, and older people's health.

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### ORCID iDs

Gwyn N Lewis  <https://orcid.org/0000-0001-9324-0940>  
Catherine M Cook  <https://orcid.org/0000-0003-3976-6858>

### Glossary

hui	meeting
iwi	tribe
kai	food
karakia	prayer
kaumātua	Māori elder
Kaupapa	purpose, ideology

kaupapa Māori	Māori approach
kōrero	talk
mahi	work
mana	prestige, power
mana āhua ake	personal autonomy
manaakitanga	kindness, respect, care
Māori	Indigenous peoples of New Zealand
mirimiri	traditional Māori massage
Pākehā	New Zealanders of British European descent
pōwhiri	welcome ceremony
rākau	plants
rongoā Māori	traditional Māori treatment
te taiao	the environment
tangata whenua	people of the land
taonga	treasured
te ao Māori	Māori worldview
Te Kāhui Māori	the Māori Advisory Committee at QE Health
te reo Māori	Māori language
te taiao	the environment
Te Tiriti o Waitangi	Treaty of Waitangi
Te Whare Tapa Whā	name of a Māori model of health
tikanga	Māori protocols
tinana	body
tino rangatiratanga	self-determination
waiata	songs
Waikato Rereahu-Maniapoto	a Māori tribe, Waikato-Waitomo, North Island, New Zealand
wairua	spirit, spirituality
whakapapa	genealogy
whakawhanaungatanga	relationship building
whānau	extended families
whānau Māori	Māori families
whanaungatanga	relationship
Whare Tapa Whā	name of a Māori model of health and well-being
whenua	land

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