Engaging kaumātua Maori and Pasifika elders in health intervention programmes in urban Auckland

Denzel Laumatia-Paki

Te Ara Poutama

Faculty of Māori and Indigenous Development

2021

Karakia

Te Waka Taua o Ngāti Paoa: Te Pītau Whakarei

Tuia ki te rangi, Tuia ki te papa
Tuia te ira atua, te ira tangata
Ka rongo te pō, Ka rongo te ao
Paoa ki uta, Paoa ki tai
Kia pono, kia tika, kia aroha
Kia tau iho mai ngā manaakitanga ki runga i a tātou
Haumi e, hui e, tāiki e!

Bind the sky, bind the earth
Bind the heavenly essence, bind the human essence
The night senses, the light senses
Paoa of the land, Paoa of the sea
Be true, show integrity and compassion
Let blessings descend upon us
Bound, together, as one.

The *karakia* is the ancestral prayer of Te Waka Taua o Ngāti Paoa, my people. In essence it recognises the presence of my tīpuna, affirms their guidance, and acknowledges those who are involved within the research.

Abstract

Mainstream New Zealand health providers struggle to engage Māori and Pasifika elders effectively. As a result, their quality of life is often compromised. The purpose of this study is to investigate what is needed to encourage Māori and Pasifika participation in health services that can improve wellness. The research question asks: What are the barriers to Māori and Samoan elderly participation in mainstream health services? A mixed methodological approach predicated on Māori and Pasifika paradigms underpins the research process. The qualitative, in-depth interviews provide an opportunity for kaumātua and elderly Samoans to articulate their views. The consensus is that the integration of cultural beliefs and values empower elders to live their highest quality of life. This research also has the potential to support healthcare providers to deliver effective care to Māori or Pasifika elders.

Table of Contents

KARAKIA **1**

TE WAKA TAUA O NGĀTI PAOA: TE PĪTAU WHAKAREI 1

ABSTRACT **2**

LIST OF FIGURES 5
LIST OF TABLES 5
KEY TERMS USED IN THIS STUDY 6
Kaumātua *6*
Pasifika *6*
Polynesian *6*
Elders *6*
Healthcare Service Interventions *7*
THE USE OF TE REO MĀORI AND THE SAMOAN LANGUAGE 7

ATTESTATION OF AUTHORSHIP **8**

ACKNOWLEDGEMENTS **9**

ETHICS DECLARATION **10**

CHAPTER 1: INTRODUCTION **11**

Implications of COVID-19 ..... *11*
COVID-19 in Aotearoa, New Zealand *11*
Pasifika Contributions *12*
RATIONALE 12
STRUCTURE OF THE THESIS 12
Chapter 2: Positioning the Researcher *12*
Chapter 3: Literature Review *13*
Chapter 4: Research Design and Methodology *13*
Chapter 5: Results/Findings *13*
Chapter 6: Conclusion *13*

CHAPTER 2: POSITIONING THE RESEARCHER **14**

ME, DENZEL LAUMATIA-PAKI 18

CHAPTER 3: LITERATURE REVIEW **20**

HEALTH INTERVENTIONS IN AOTEAROA NEW ZEALAND 21
MĀORI: TANGATA WHENUA 23
Whakapapa and Whānau *24*
Whenua *26*
Improving Health Interventions for Māori *26*
PASIFIKA 27
Pacific Collectiveness *29*
Religious Centrality *29*
Improving Health Interventions for Pacific People *30*
MOVING FORWARD 30

CHAPTER 4: RESEARCH DESIGN AND METHODOLOGY **32**

RESEARCH PARADIGM 32
Case Study Approach *33*
METHODOLOGICAL APPROACHES 34
KAUPAPA MĀORI AND FA'A SAMOA 34
Te Whare Tapa Whā *36*
Poutu *36*
RESEARCH METHODS 38
Geneology: Whakapapa and Gafa o Samoa *38*

Whānaungatanga and Fa'aaloalo *38*
Kanohi ki te Kanohi and Kanohi Kitea *39*
QUALITATIVE RESEARCH METHODS 39
DATA GATHERING METHODS 41
RESEARCH QUESTIONS 41
DATA ANALYSIS 42
Thematic Analysis *42*
CONCLUSION 42

CHAPTER 5: RESULTS/FINDINGS 43

THEME 1: WHĀNAU AND AIGA (FAMILY) 44
The Foundations *46*
The Body Ages, but the Foundation Remains the Same *46*
Whānaungatanga – Being Amongst Others *47*
THEME 2: MOTIVATIONS FOR WELLNESS 49
Doing What is Important – Cultural Connectedness *50*
Doing it For Those Who Matter *51*
THEME 3: BARRIERS 52
Cost an Issue *52*
Language a Barrier *53*
The Lack of Familiarity with Providers *53*
Fear of Judgement *54*
Social Isolation *54*
Unaware of Services *54*
THEME 4: HEALTHCARE SERVICES 55
Influence of Title *56*
A Whānau-centric Approach *57*
THEME 5: RESPONSE TO COVID-19 57
The Bad *57*
The Good *58*
Prayer *58*
CONCLUSION 59

CHAPTER 6: CONCLUSION 60

ETHNIC-SPECIFIC DETERMINANTS AND POTENTIAL APPLICATIONS 62
FUTURE RESEARCH 63

REFERENCES 64

APPENDIX 75

LETTER OF SUPPORT FORM WAITI COMMITTEE 75

List of Figures

Figure 1. *Charlie and Hune Paki, and Sesa and Mautoatasi Laumatia*

Figure 2. *Laumatia Aiga*

Figure 3. *Paki Whānau Wānanga*

Figure 4. *Paki Whānau Traversing the Hau Kainga*

Figure 5. *Samoa, Sa'anapu: My Village*

Figure 6. *North Island of New Zealand/Aotearoa, Waiti Marae*

Figure 7. *Denzel and Keanu Laumatia-Paki*

Figure 8. *UniPrep Mentor Tug of War Battle*

Figure 9. *Physical Activity of Adults in New Zealand*

Figure 10. *Physical Inactivity of Adults in New Zealand*

Figure 11. *Te Whare Tapa Whā Framework*

Figure 12. *Poutu Framework*

List of Tables

Table 1. *Differences Between Pākehā Fundamental Values and Māori and Pacific Peoples' Values*

Table 2. *Interview Participants' Demographic Profiles*

Key Terms Used in This Study

In this thesis, I use several words that are significant throughout the entirety of this document. However, given this study's cultural and technological nature, I am aware that definitions can vary depending on the context. Therefore, a brief description of the meanings of commonly used words throughout the thesis may be helpful.

Kaumātua

The term *kaumātua* is used frequently and is typically associated with a Māori elder; males are known as *koroua* (or koro for short), and females as *kuia*. For a person to be deemed a kaumātua typically depends on age and traditional knowledge. In *te ao Māori* (the Māori world), kaumātua are important figures. They are recognised for the life experiences and knowledge they have attained over the years. Historically, kaumātua were the family leaders and often made decisions regarding *whānau*, *hapū* and *iwi* (family, sub-tribes and tribes) (Mead, 2003).

Pasifika

In this thesis, *Pasifika* (or *Pasefika*) refers to people living in Aotearoa, New Zealand, who have migrated from the Pacific islands, including Samoa, Tonga, Niue, Cook Islands, Tuvalu, and other smaller Pacific nations. Pasifika can also be used for those identifying with the Pacific Islands because of ancestry or heritage (Pasefika Proud, 2016).

Polynesian

The term *Polynesian* is Greek for “many islands”. Thus, it refers to a diverse range of ethnic groups situated within a triangle over the central and southern Pacific Ocean. The triangle stretches from Hawaii in the north and extends to Easter Island in the east and New Zealand in the west (Buck, 1954). Within the context of this research, the word Polynesian is used to represent the relevant Pacific nations and Māori people.

Elders

In this study, the term *elders* is indicative of older adults. However, unlike the conventional Western definition, the phrase does not bear the stigma of frailty or other negative stereotypes (Stypinska, 2009). From a Māori and Pacific worldview, our elders are highly esteemed; they have a critical role as leaders within the family and society. It is through the elders that the passing down of traditional knowledge is continued. We subconsciously observe, follow and go on to teach our own families their teachings. It is through our elders that the spirit of Māori and Pacific culture is kept alive.

> Older individuals generally have a greater familiarity with and knowledge about tikanga because they have participated in tikanga, have observed interpretations of the tikanga at home and other tribal areas. The kaumātua and kuia, the elders, are often the guardians of tikanga. (Mead, 2003, p. 14).

Healthcare Service Interventions

Healthcare service interventions are a significant aspect of this research, particularly the analysis of engagement measures for Māori and Pasifika elders. According to the World Health Organization (2020), a health intervention is a combination of programme elements or strategies designed to assess, improve or maintain health status among individuals or populations. Therefore, within this research, the term healthcare service interventions is in reference to the health programmes of Aotearoa, New Zealand.

The Use of Te Reo Māori and the Samoan Language

As a Māori and as a Samoan, it is important to me to recognise the prominent cultures that contribute to my makeup by using the languages within this thesis. Furthermore, the use of *te reo Māori* (the Māori language) and Samoan words further acknowledges my grandparents' native tongues; it is my spiritual connection to them.

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Denzel Laumatia-Paki

14 July 2021

Acknowledgements

Ehara tāku toa i te toa takitahi, engari he toa takitini

My success is not mine alone but that of many

This thesis is dedicated to my grandparents; matua o lo'u tinā, Mautaotasi and Sesa Laumatia, and my tīpuna, Charlie and Hune Paki.

Figure 1

Charlie and Hune Paki, and Sesa and Mautoatasi Laumatia

Note. Author's photograph.

I want to acknowledge my supervisor, Professor Hinematau McNeill. With a deep appreciation, I thank you for your guidance, wisdom, patience, and undying support throughout my thesis adventure. You have been beside me every step of the way, and I am forever grateful.

To my participants, thank you for your stories, your insights, and your words of wisdom. I hope this work captures your contributions meaningfully. This one is for you and all Māori and Pasifika.

I express my gratitude to Te Ara Poutama The Faculty of Māori and Indigenous Development. You welcomed me into a space that has allowed me to grow, learn, and, most importantly, thrive. But it is more than just a faculty; it is a home away from home, surrounded by a whānau, cheering you on.

A special mention to Ngā Pae o Te Māramatanga and the Ministry of Health for their assistance during a tough 2020. The financial support and platform to rub shoulders with a diverse range of Māori academics were inspiring and uplifting.

To my friends who have kept me uplifted during this journey, you know who you are. Thanks for putting me up and cheering me on. You are the real ones.

To my dad Wayne, my mum Josephine, and my brothers Keanu and Tai. My backbone and my all. Thank you for the endless love and support through it all. I love you, my family, so very much.

Lastly, my Paki whānau and my Laumatia aiga, we are out here! We on.

Ethics Declaration

Ethics Application 19/435 was approved by AUTEC 4 November 2020

Chapter 1: Introduction

The health interventions aimed to improve the health and wellbeing of Māori and Pasifika struggle to engage my people effectively. As a result, the quality of life of our elders is compromised. With the best intentions, health professionals have grappled with strategies to enhance programme design for older people. It has been suggested that mainstream interventions lack the necessary integration of cultural knowledge. To cater to elders', it is essential to establish cultural perspectives towards health. A deeper understanding of what defines Māori and Pasifika wellness and what hinders participation can help inform future practice. Underpinning this practice is the desire to develop the services available for kaumātua Māori and Pasifika elders, where interventions embedded in Māori and Pacific beliefs and values empower elders to live their highest quality of life.

The COVID-19 global pandemic impacted this study (the pandemic and its effects rather than the disease itself). Initially, the target group was kaumātua from my *hau kāinga* (ancestral lands). The first lockdown in Auckland coincided with the fieldwork that I was about to undertake at Tāhuna. However, the implications of COVID-19 caused problems with accessing older Māori outside of Auckland. Confined to Auckland, I decided to extend my research to include my Samoan *aiga* (family). This enabled me to continue my research. It also had the bonus of appeasing my Samoan aiga, who were slightly aggrieved on learning that my study focus was exclusively my *taha Māori* (Māori side).

Implications of COVID-19

In early 2020, COVID-19, a new form of coronavirus, was deemed an epidemic and sparked a global emergency response. The disease presents symptomatically as a common cold; however, it can affect an individual's respiratory system. Although all age groups are at risk of the virus, older people face a significant risk of developing severe illness if they are infected with the disease, due to the physiological changes with ageing and potential underlying health conditions. Within the year, over 116 million cases were reported worldwide, and of that total, around 2.59 million cases resulted in death (World Health Organization, 2021). The influx of cases led millions of people to quarantine and has forced entire cities into lockdown globally.

COVID-19 in Aotearoa, New Zealand

In Aotearoa, COVID-19 caused multiple lockdowns, and the additional resurgences of the virus continue to affect the operations of cities nationwide. The repercussions of the epidemic are even more problematic, as it has caused the loss of employment, restrictions to socialisation and impacted the ability to achieve necessary physical activity requirements.

A plausible cultural issue with Polynesian communities is the impact on social wellness. In particular, social isolation from the lockdown affected the normalities of staying connected in person. Polynesian cultures frequently operate in communal ways, and therefore these repercussions further coincide with the issues already affecting older Māori and Pasifika.

Pasifika Contributions

Initially, this research predominantly focussed on the health inequities of Māori kaumātua. However, COVID-19 caused a rethink of the methodology to include Pacific participants, as the Pacific population, like Māori, are reflected poorly within health datasets. In addition, the inclusion of Pasifika brings to the research another dimension of Indigenous knowledge. This knowledge contains crucial information that can help to interpret and contextualise Pasifika health and the deficit statistics within Aotearoa, New Zealand. Furthermore, the correlation of two bodies of knowledge, the kaupapa Māori and Pasifika framework, allows an opportunity to draw more comparisons to the current status of healthcare service interventions.

Rationale

The rationale for this inquiry is the need to address inequities of health prevalent among Māori and Pasifika elders. The repercussions of colonisation and the imposition of Western-centric approaches to healthcare services does not create a safe space for the participation of Māori and Pasifika people. Therefore, health services designed within the Western biomedical model continue to deter Māori and Pasifika engagement. Drawing on Māori and Pacific worldviews, this study rethinks how we might perceive the complexities of health regarding the determinants of wellness for older Māori and Pasifika people. The constituents that inform wellness for Polynesian elders may prove beneficial for the improvement of future programme design. Understanding the determinants of wellness for Māori and Pasifika elders will provide an insight into what contributes meaningfully to health, which can help inform the design of current health care services and interventions.

Structure of the Thesis

Chapter 2: Positioning the Researcher

The second chapter positions me, the researcher, by explaining my background and life experiences that have led and connected to this thesis. The chapter is meaningful because it draws from my upbringing as a Māori and a Samoan and the complexities of urbanised living. It reflects on the significance of my dual heritage and the contribution this has on my identity. I am truly blessed to have the richness of both cultures shape who I am. It also gives some insights into my feelings towards the older people, my acknowledgement of their knowledge they have and my desire to support their health and wellbeing.

Chapter 3: Literature Review

The third chapter presents a critical overview and analysis of the existing literature. The texts reviewed cover areas of Māori health, Pacific people's health, older adult health and wellness and advanced ageing. The chapter displays statistical evidence referring to health interventions in Aotearoa, New Zealand, and then traverses the range of themes relevant to the health barriers for Māori and Pacific people, the importance of culture and family, the impact of colonisation, and the Western-centric approach to wellness. Critiquing the existing literature indicates the constituents that inform kaumātua Māori and Pasifika elders' engagement in mainstream healthcare interventions.

Chapter 4: Research Design and Methodology

The fourth chapter considers the research design and methodology underpinning the inquiry, a kaupapa Māori paradigm informed by Pacific ontology and epistemology, supported by qualitative research methods. The research discusses the Poutu and Te Whare Tapa Whā frameworks and draws from kaupapa Māori theory and *fa'a Samoa* (Samoan way) methodology. The analysis uses semi-structured interviews to capture the perspectives of kaumātua Māori and Pacific elders and their interpretation of wellness through their personal experiences. Finally, a case study approach methodology is used to extrapolate the data relevant to what informs the engagement of kaumātua Māori and Pasifika elders in healthcare interventions.

Chapter 5: Results/Findings

The fifth chapter brings to light the responses from the interviews. The analysis of the interviews identifies what informs health and wellness for kaumātua Māori and Pasifika elders. Understanding what contributes meaningfully to an older Māori or Pacific person's wellness provides insight into what is essential; these insights can be used to improve current healthcare services and program design. This work recognises the cultural diversities of Māori and Pacific people and briefly highlights the similarities that enhance wellness.

Chapter 6: Conclusion

Lastly, this chapter reports on the critical points of the research project from the interviews and documents the findings to create correlations with the literature. It discusses contributions to the field and then suggests the potentiality of future research.

Chapter 2: Positioning the Researcher

Ka tū ana ahau, ka ūhia au e ōku tīpuna.	***E leai se mea e sili atu i lo lou aīga***
Wherever I stand, I am clothed by my ancestors	Nothing is more important than your family

I am an extension of my grandparents–a proud, dual ethnic Māori/Samoan, born and raised in *Tāmaki Makaurau* (Auckland). Service to others, having pride in my identity, working hard; these are only some aspects of many values they instilled in me. My grandparents are representative of these fundamental values. They laid the foundations of what makes me, and my family members are the pillars that keep me uplifted.

Throughout my life, I have experienced the hardship of seeing older family members in poor health. It has impacted negatively on my wider family and has made me aware of the wellbeing of my grandparents. In recent years, I have realised their value and the influence they have had on the way I lead my life. The importance of our elders is not unique to me, but to all Polynesians.

For as long as I can remember, I have always battled with the loss of my *tīpuna* (Māori grandparents); my whole *whānau* (Māori family) has struggled. Once Koro Charlie, my grandfather, and Kuia Hune, my grandmother, passed away, my wider whānau stopped coming together. Naturally, due to other life events, we all drifted apart, and much of the transmission of *tikanga Māori* (Māori knowledge) was suspended. Initially, as mentioned in Chapter 1, my focus was on my taha Māori, to reinforce our recent reconnection to my father's people and my kuia (grandmother) and koroua (grandfather).

Unlike my father's side, my mother still has her parents thriving through older age. My *matua o lo'u tinā* (my grandparents on my mother's side) have been the glue that has kept my aiga (Samoan family) tight-knit. Growing up, I expected to see my aiga frequently; we had *lotu* (prayer) twice a month, *to'onai* (family lunch) for every celebration, and other various extended-family events. My engagement with activities relevant to my aiga naturally informed my knowledge of my Samoan culture, and these experiences are now what guides me through anything Pasifika.

Figure 2

Laumatia Aiga

Note. Author's photograph.

My familiarity with my Samoan culture stood in contrast to my Māori heritage until my tertiary education years. Although I looked Māori, had Māori blood, and could *whakapapa Māori* (trace genealogical descent to my Māori ancestors), I often felt alienated and *whakamā* (embarrassed) in any Māori space. The pressures of urban living further exacerbated my identity crisis and my ability to stay immersed in customs and traditions. This is typical of the Māori and Pasifika diaspora; the chasm between the city lifestyle in Tāmaki Makaurau and rural living back home, with different ways of living. Paradoxically, although I felt I lacked a connection to my Māori roots, I always drew close to te reo Māori (the Māori language), *kapa haka* (Māori performance), and *waiata Māori* (Māori music).

In recent years, the passing of my Uncle Leon, the first of my immediate whānau, brought us back together. During this challenging time, we shared stories, resources and re-established togetherness. From then, my desire to draw closer to te ao Māori (the Māori way) was ignited, as it was for my whole Paki whānau.

Figure 3

Paki Whānau Wānanga

Note. Author's photograph.

A year from the passing of my Uncle Leon, at his tombstone unveiling, I realised that my sense of disconnection and lack of cultural identity was not mine alone. Conversations with my Paki cousins revealed that we all felt alienated towards Māoridom. We discovered then and there that the premature loss of our tīpuna was a part of a much bigger picture, our *tūturu whakapapa* (authentic sense of genealogy).

In the last year, all of the Paki whānau have been on a whakapapa journey on the same *waka* (boat), paddling towards a shared *kaupapa* (purpose). We have participated in our whānau-led *wānanga* (educational seminars). We have begun taking the necessary steps to affirm our sense of self as *tangata whenua* (people of the land).

Figure 4

Paki Whānau Traversing the Hau Kainga

Note. Author's photograph.

A part of me has always wondered what life would have been like with my tīpuna. I have often questioned if Koro Charlie Paki and Kuia Hune Paki would have benefitted from the use of suitable healthcare services. Although the services are no longer beneficial to them, they can still influence my matua o lo'u tinā and the broader Māori and Pacific communities. This thought process has been the catalyst that has guided me into further higher education.

This research and the use of relevant traditional knowledge will further strengthen my relationship with fa'a Samoa and my hau kainga, Ngāti Paoa.

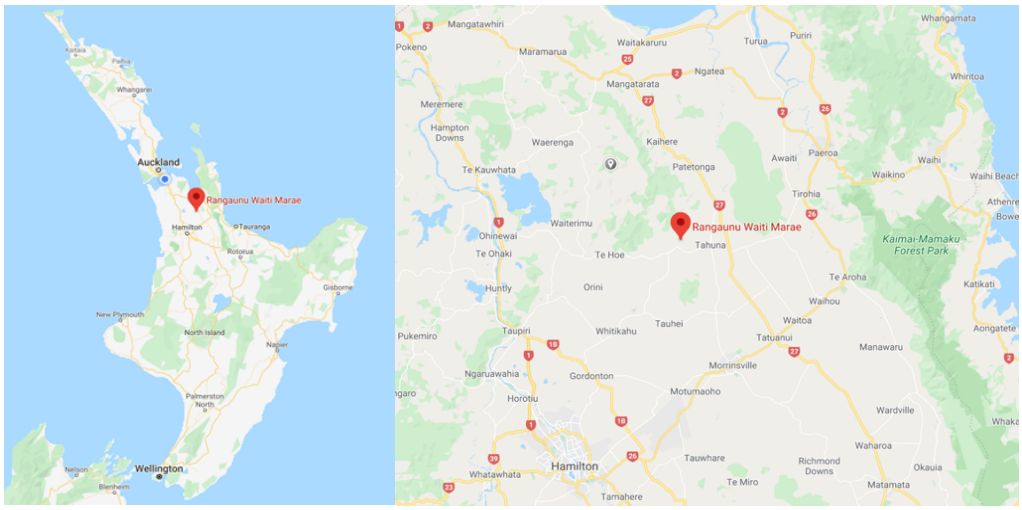
Figure 5

Samoa, Sa'anapu: My Village

Note. Maps data copyright by Google, 2020.

Figure 6

North Island of New Zealand/Aotearoa, Waiti Marae



Note. Waiti Marae is one of the hau kainga of Ngāti Paoa. Maps data copyright by Google, 2020.

Me, Denzel Laumatia-Paki

Ngāti Paoa ki uta, Ngāti Paoa ki tai, Ngāti Paoa ki tua o te pae o Matariki

Ngāti Paoa venturing inland, Ngāti Paoa venturing to the sea, Ngāti Paoa venturing into the future

Figure 7

Denzel and Keanu Laumatia-Paki

Note. Author's photograph.

As a strength and conditioning coach, I possess a knowledge of health and exercise science that enables me to bring a specific skill set to the research. The role relies on exercise prescription to improve athletic performance in high performing individuals. I also have expertise in injury prevention. Applying this knowledge and practice to the study of kaumātua Māori and Pasifika elders allows my aspirations and professional skills to intertwine.

In 2016, I first became involved in an educational programme as a mentor for UniPrep, an initiative from the Auckland University of Technology (AUT). The Office of Pacific Advancement (OPA) at AUT created UniPrep and other initiatives to address education inequities in low decile areas in Tāmaki Makaurau, Auckland. The experience as a mentor was life-changing. I worked alongside other influential mentors to support students who fall within the deficit statistics of education in Aotearoa. I witnessed first-hand some of the adversities that students battle with, and the initiative's impact inspired me. Like most OPA initiatives, it was developed using Polynesian frameworks. UniPrep showed me the benefits of culturally tailoring education programmes and the positive impact on their students.

Figure 8

UniPrep Mentor Tug of War Battle

Note. Author's photograph.

In 2017, my experiences from employment at OPA motivated my desire to pursue higher education. At the time, I was navigating my whakapapa journey with the Paki whānau. The revelations of my identity crisis coincided with the loss of my tīpuna and the health datasets for kaumātua Māori and Pasifika elders. I then decided to commit to research that would benefit older Māori and Pasifika people; it was my offering of respect to honour my tīpuna and matua o lo'u tina.

I am acutely aware of the health status of Māori and Pacific communities in Aotearoa, and I'm compelled to use my knowledge and practice to support a wellness plan for older Māori and Pacific people. It is my hope that this thesis, informed by Māori and Pacific knowledge, contributes meaningfully to te ao Māori and Pasifika.

Chapter 3: Literature Review

This chapter provides a critical overview and analysis of knowledge related to the study. It is divided into four major sections. The first contextualises health interventions in Aotearoa, New Zealand and provides the rationale for consideration. The second examines health disparities among Māori and identifies the specific elements of Māori knowledge that contribute to te ao Māori and wellness. The third considers health disparities among Pasifika and explores the understandings of Pasifika values that contribute to the wellbeing of *Tangata Pasifika* (people of the Pacific).

There is a paucity of research into elderly Māori and Pacific health and wellness. However, this generation sits within a broader context of kaupapa Māori theory, Māori health, Pasifika health, older adult healthcare services and active aging. Arguably, mainstream research approaches have misinterpreted the understanding of Māori and Pasifika aging populations (Allen et al., 2019; Guiney et al., 2018; Kerse et al., 2005; Penney et al., 2011; Prior et al., 1966; Reid & Robson, 2007). The ongoing concerns is that Western-centric processes and practices have proven to be culturally inappropriate for Māori, Pasifika and other minority groups (Bathgate et al., 1994; Bishop, 1998; Esera, 2001; Reid & Robson, 2007; Maldonado-Torres, 2011; Wirihana & Smith, 2014; Zavala, 2013). The development of kaupapa Māori theory is the response, to authenticate Māori realities and help address colonisation in Aotearoa. (Curtis, 2016; Irwin, 1994; N. Mahuika, 2011; Pihama, 2010). The status of health disparities indicates the need for mainstream health interventions to integrate kaupapa Māori practices, to develop more reliable services for Māori, Pacific communities, and minority groups.

In Aotearoa, as in many other developed countries, older people's health impacts public spending (Avendano et al., 2009; Christensen et al., 2009; Ministry of Health, 2009). Within the last decade, the District Health Board's spending on services for older populations has increased exponentially (New Zealand Treasury, 2017). Health interventions specifically designed for older adults are available to help combat health inequalities. Typically, they are designed to educate about the importance of physical activity and proper nutrition.

Although modern-day health initiatives have proved to be a beneficial way to address health disparities in older age, these interventions struggle to engage specific ethnic groups effectively. Kaumātua Māori, older Pasifika, and elderly Indigenous peoples, in general, are among the most disadvantaged, as the health services at present are often developed through a Western lens. Understanding their perspectives of wellness will help combat the

underrepresentation in mainstream health intervention. (Goins et al., 2011; Griffin-Pierce et al., 2008; Holkup et al., 2007; Warbrick et al., 2016).

Health Interventions in Aotearoa New Zealand

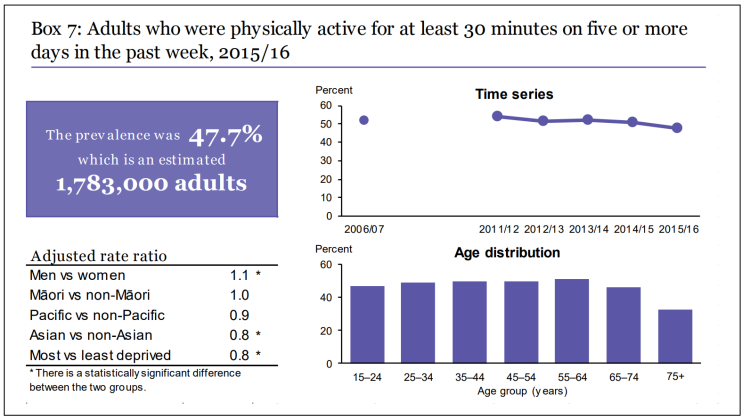
It has been well established that living a healthy lifestyle is paramount to improving life quality. The human body is designed to move as an essential requirement to achieve vitality and sustain health (Owen et al., 2010; Wankel, 1993; Warburton, 2006; Wen et al., 2011). Recently, there has been an influx of literature that demonstrates the benefits of physical activity and recognises that frequent exercise can prevent diseases (Lee et al., 2012; Loprinzi & Frith, 2018; Yamashita et al., 2018; Hately & Mandic, 2019; Wankel, 1993; Warburton, 2006; Wen et al., 2011).

Long-term health conditions associated with physical inactivity are becoming more apparent. Among the most common are diabetes, coronary heart disease, stroke, and renal failure (Elley et al., 2003; Schmid & Leitzmann, 2014; Lee et al., 2012). The Mortality Collection Data Set indicates chronic diseases dominate premature deaths in New Zealand; in particular, ischaemic heart disease is the leading cause of premature deaths (Ministry of Health, 2019). Individuals who are physically inactive or live sedentary lifestyles are more likely to die prematurely than active individuals (Booth et al., 2012; Myers et al., 2004).

The tables from the Ministry of Health (2016) shown in Figures 9 and 10 display the most recent physical activity levels across all age groups and ethnic backgrounds in New Zealand. These tables indicate that the percentage of physically active adults has continued to decrease over time, and the rate of physical inactivity has increased. The Ministry of Health (2016) recommends 150 minutes of physical activity of moderate intensity per week; this can be broken into 30 minutes per day at least five times a week.

Figure 9

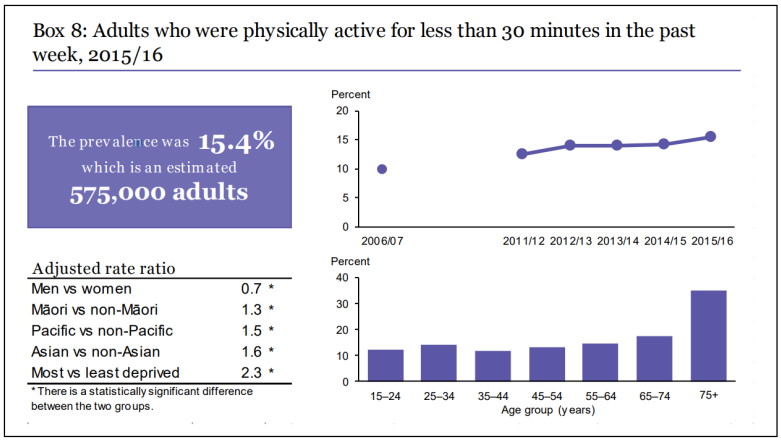
Physical Activity of Adults in New Zealand



Note. Adults who were physically active for at least 30 minutes on five or more days.
From *Annual Update of Key Results 2015/16: New Zealand Health Survey*, by Ministry of Health. 2016 (https://www.health.govt.nz/publication/annual-update-key-results-2015-16-new-zealand-health-survey). CC-BY 4.0.

Figure 10

Physical Inactivity of Adults in New Zealand



Note: Adults who were physically active for less than 30 minutes in the past week. From *Annual Update of Key Results 2015/16: New Zealand Health Survey*, by Ministry of Health. 2016 (https://www.health.govt.nz/publication/annual-update-key-results-2015-16-new-zealand-health-survey). CC-BY 4.0.

The diagrams presented in Figures 1 and 2 illustrate the rise in physical inactivity within the last decade. It is noteworthy that physical activity levels differed among ethnic groups; moreover, Māori and Pasifika people are more likely to be physically inactive.

Burgeoning evidence supporting the importance of physical activity has been a driver for developing health interventions. Implementation of health-related programmes is a reasonable

measure for injury and disease prevention that is inexpensive compared to the cost of hospitalisations and disease management (Kerse et al., 2005; Christensen et al., 2009; New Zealand Treasury, 2017; Hobbs et al., 2019). Keogh et al. (2014) highlight health promotion interventions as beneficial and suitable for entire populations, especially older adults. A study from Hamlin et al. (2016) supports this notion and found that participants of their programme "The Green Prescription" reported significant improvement in overall physical activity levels, a mean score of +64 min per week for the studied group. Numerous authors document that adherence to health programmes by older adults results in social engagement, more excellent self-reported health, improved cognitive performance and overall better quality of life (Kerse et al., 2005; Warbrick et al., 2016; Sims-Gould et al., 2019).

Although preventative strategies are designed to improve older people's quality of life in New Zealand, the limited representation of Māori and Pasifika in these programmes is challenging (Gifford et al., 2017). The inability of healthcare services to effectively engage an equal range of ethnic diversity further increases health disparities for Māori and Pasifika.

Māori: Tangata Whenua

Disparities in health between Māori and Pākehā have been evident across a long history and date back to colonial times. Today, colonialism has severely disrupted Māori people's ways of being and relation to the land (Reid et al., 2016; Dyall et al., 2014; Mark & Lyons, 2010). Intergenerational trauma has impacted the cultural and psychological wellbeing of Māori (Bishop, 1998; Peace et al., 2005; Murton, 2012). Researchers have established that Māori people are usually within the highest percentage of deficit statistics, including education, poverty, unemployment, mental health, suicide, addiction, crime and prison figures (Reid et al., 2016; Pihama et al., 2014).

These disparities may be explained by a number of factors. Guiney et al. (2018) and Ellison-Loschmann and Pearce (2006) highlight lifestyle, socioeconomic factors, access to healthcare services, and discrimination as contributing to health inequalities between Māori and non-Māori. These factors severely impact the quality of life for most Māori, and in most cases, have conflictual implications to healthcare services.

At present, numerous health initiatives across Aotearoa are established upon the foundation of Western paradigms, emphasising an individual's physical wellbeing. In some cases, this has proved beneficial to influence health outcomes; however, Gifford et al. (2017) believe it does not fully address the prominent 'gap' in health among ethnic groups.

The notion of solely focussing on singular aspects of health is now contradicted through the creation of kaupapa Māori frameworks. Durie (1994) developed the health model Te Whare Tapa Whā to better illustrate the Māori worldview of health as a holistic concept. Te Whare Tapa Whā identifies four cornerstones relevant to Māori health: *te taha wairua* (spiritual), *te taha tinana* (physical), *te taha hinengaro* (mental), and, *te taha whānau* (family) (Rochford, 2004). Te Whare Tapa Whā provides a practical way for people to understand wellbeing as a *whare* (house). The whare has four walls, with each wall symbolising a different dimension essential to Māori health and wellbeing. If any of these dimensions are deficient, this will negatively impact the whare as a whole. Therefore, when all four walls are solid and balanced, so is a person's health. Durie (1994) identified and popularised the idea that ethnic divergence affects perspectives of wellness.

The differences between Māori and non-Māori, and their perceptions about what contributes meaningfully to wellness, is likely to account for the varying participation levels in health services and interventions. Hamlin et al. (2016) believe that prescribed physical exercise programmes are helpful and can benefit kaumātua. However, this is contradicted by several researchers who insist the absence of cultural values incorporated into programme designs impacts Indigenous participation (Barnett & Kendall, 2011; Lavoie et al., 2010; Warbrick et al., 2016; McMurray & Param, 2008). The reliance on Western health paradigms and the medical model indicates a dominant Western culture, which is likely to contribute to Indigenous health disparities.

The research shows that the approach of 'one-size-fits-all' integrated into health services has limited application within the context of varying ethnicities. Although universal indicators and measures can be applied to Māori, as they can to other populations, there are also unique characteristics of Māori that require specific measurement (Te Puni Kōkiri, 2010)

Whakapapa and Whānau

Whakapapa (genealogy) is central to Māori perceptions of existence and is at the core of what it means to be Māori. The literal translation of whakapapa is to 'place in layers'. It involves multiple layers and interpretations that form the basis of Māori values and beliefs. Whakapapa is a way of thinking and knowing and is fundamental to almost every facet of a Māori worldview. The importance of whakapapa within Māori culture cannot be overestimated. It acts as a basic form of knowing an epistemological template. This entry explores the centrality of whakapapa to Māori of knowing, learning, and ways of being in the world (Rameka, 2016).

Relationships are not only through the living, but they also transcend through ancestral generations before (A. Mahuika, 1998; Marsden, 1992). Although we function in a post-colonial

environment, Indigenous world views continue to influence our beliefs, values, and practices (Boulton et al., 2010; Boulton et al., 2013; Chant, 2011; Metge, 1995).

Oetzel et al. (2019b) correlates and analyses the responses of 209 self-reported health-related surveys completed by kaumātua. The study concludes that whakapapa affirms a stronger sense of identity and culture. They also acknowledge the effectiveness of understanding Māori *tikanga* (protocols). Moreover, within this study kaumātua report that the inclusion of tikanga enhances the quality of life for Māori.

The work of Wright-St Clair et al. (2012) reinforces the importance of whakapapa and goes further to highlight the significance of whānau (family). This comparative study analyses the activity preferences of older Māori and non-Māori. They find that, in advanced age, both Māori and non-Māori have similar interests in activity preferences; however, Māori typically prioritise activities that collectively promoted ancestral connectivity and community. Their research concludes that the concept of whānau is dynamic and extends further than an individual's immediate family; it is interconnected across generations. The relationships to people and other supreme entities are significant, when considering Māori wellness.

Mark and Lyons (2010) capture traditional Māori knowledge through the interviews of Māori spiritual healers'. The research identifies the importance of tīpuna (ancestors), their acknowledgment, and their implications on wellness. In particular, the authors mention communication with tīpuna, considerations of whānau transgressions from past generations, and the importance of connections to the *whenua* (land). The study identifies Māori people's relation to their whakapapa as an essential component contributing to their spiritual health.

Successful engagement with Māori communities requires understanding cultural relationships, including relations to others, past and present (Graham, 2009; Hau'ofa, 1985; Warbrick et al., 2016; Mark & Lyons, 2010; A. Mahuika; 1998; Oetzel et al., 2019a). Cultural obligations to the whānau and community are essential for an improved sense of wellbeing. Healthy relationships with others, especially whānau, are imperative, because they positively impact on levels of physical activity.

> If you look at success, you'd see that the majority of successes with Māori men occur when the relationship is strong and the whānau becomes stronger. When the relationship between the two is strong it doesn't matter if it's the male's strength or the woman's strength, but where that relationship is able to build and grow then the whole whānau and the whole iwi becomes strong. (Warbrick et al., 2016, p. 6)

Whenua

Relationships between the people and the land are the basis of what informs *tangata whenua* (people of the land). For generations, the land has been sacred to Māori, who have spiritual ties to the whenua, Papatūānuku, the earth mother (Graham, 2009; Marsden, 2003; Mead, 2003). Māori relate to the whenua through whakapapa; their tīpuna were guardians of the land, and through the land, they have established relationships (Harmsworth & Awatere, 2012; Kawharu, 2000; Marsden, 1992). Māori are entrusted with guardianship over their land, providing a sense of purpose and belonging. The whenua relates to all aspects of existence–culture, spirituality, whakapapa, whānau and identity.

Māori iwi (tribal groups) are often referred to by their local geographical areas, such as a *maunga* (mountain) or *awa* (river), and it is through these shared places that they can connect to others. Pepeha are becoming a ubiquitous ritual, identifying tribal membership and developing deeper understandings of and connectedness to the Māori world–past, present and future. A pepeha is a way of introducing oneself to others. It is based on whakapapa and tells one's story, one's affiliations to people, places and events, relationships to the environment and one's connectedness to the spiritual realm. It addresses questions critical to identity as a Māori (Rameka, 2016b, p. 391).

Butcher and Breheny's (2016) findings suggest that Māori people associate the whenua with increasing an individual's sense of self. Their research examines the ways that location influences experiences of ageing for older Māori in New Zealand. The responses of eight older Māori express that familiarity and comfortable dependence on the whenua and their whānau, enabling their autonomy in later life.

Mark and Lyons (2010) emphasise the importance of whenua, and explain that the whenua links Māori people to their ancestors and other people. Another notable finding within their research highlights the perspectives of Māori healers. It is believed that the relation to the whenua is so sacred that the mistreatment of the land can have implications for a person's spiritual health. Durie (2001) explains the connection to the whenua as a crucial relationship for Māori, because it provides a place of unity, a sense of identity, and life sustenance.

Improving Health Interventions for Māori

He Korowai Oranga: Māori Health Strategy is a positive strategy because it is more pragmatic than the Ministry of Health's previous aspiration objectives. Improvements in health inequalities will give credence to the innovative design. The significance of *He Korowai Oranga* is exemplified in the work of Oetzel et al. (2019a). They argue that service providers should look to better understand the importance of tikanga Māori (protocols) and

that integration of kaupapa Māori principles will enhance program design, to help better manage emotional and socio-emotional factors for kaumātua Māori.

He Korowai Oranga: Māori Health Strategy has been the overarching framework that informs the government's health and disability sector to better outcomes for Māori. It involves implementing a holistic approach to health that takes cognisance of Māori ways of thinking and doing. *Whakamaua,* the Māori Health Action Plan, is the outcome of a review to address disparities in Māori health. The strategy has four key objectives: 1) Iwi, hapū, whānau and Māori communities exercising their authority to improve their health and wellbeing; 2) Ensuring the health and disability system is fair and sustainable and delivers more equitable outcomes for Māori; 3) Addressing racism and discrimination in all its forms; and 4) Protecting mātauranga Māori throughout the health and disability system.

Pasifika

The increasing rate of health disparity in Aotearoa is troublesome as it affects Māori but also has extended across various ethnic groups. The disparities in health outcomes for Māori people resonate with the significant health inequities between Pacific and non-Pacific people in Aotearoa. These are well-reported within research, despite Pacific people being able to access the same health services as other New Zealanders (McLaughlin & Braun, 1998; Wright & Hornblow, 2008; Came et al., 2016; Rodriguez et al., 2017; Came et al., 2019; Ryan et al., 2019). Pacific people's health outcomes and inequities are reflected in the higher rates of chronic diseases: obesity, Type 2 diabetes, and cardiovascular diseases (Blakely et al., 2007; Holt & Karalus, 2017; Rodriguez et al., 2017; Came et al., 2019). The prevalence of obesity in Pacific people, for example, is 2.5 times more likely compared with non-Pacific adults (Ministry of Health, 2019).

Research on Pacific people has identified that the understanding of wellness is strongly affected by a narrative of poverty and limited resources. Talemaitoga (2011) points out that challenges faced by Pacific people are determined by socioeconomic factors, which has significant implications for Pasifika health and wellness. Concerns have also been raised linking poorer outcomes to the lack of economic resources, high levels of stress, and family obligations (Cowley et al., 2004; Sa'u Lilo et al., 2020; Schluter et al., 2007; Wright and Hornblow, 2008).

The gap in health equities prevalent between Pacific and non-Pacific people has been prominent across a long history. Like Māori, the livelihoods of Pacific communities living in Aotearoa have also been affected by colonisation. The history of the New Zealand government's colonial

engagement with the Pacific region dates as far back as the 20th century and is still the subject of ongoing research and commentary (Thomsen et al., 2018).

Pacific people have been traversing back and forth to Aotearoa for at least a thousand years, and the Indigenous people of Aotearoa had sailed from the Pacific to far south to settle on this land. Thomsen et al. (2018) acknowledges that most New Zealand Pacific communities (90%) share common Polynesian ancestry, which has obvious implications regarding shared fundamental values and beliefs.

Values and beliefs are the core of each culture's way of being, which informs how people interact with the world and other human relationships. Tamasese et al. (2010) describes what they call "significant differences between Pākehā [Non-Māori] fundamental values and Māori and Pacific peoples' values," which are presented in Table 1:

Table 1

Differences Between Pākehā Fundamental Values and Māori and Pacific Peoples' Values

Pākehā	Pacific People/Māori
• Individual • Secular • Consumer • Conflictual	• Communal • Spiritual • Ecological • Consensual

Although the table compares ideological differences, there is context. Firstly, these Pākehā values developed in tandem with the European industrial revolution and imperialism. The colonial experience has influenced Post-colonial Māori values. A decolonising agenda requires revisiting *tūturu* (authentic) Māori and Pacific beliefs and values in meaningful ways. Therefore, an understanding of cultural differences is at the heart of this research. This position is supported by Pasikale et al. (1995), who identifies individualism as the essence of mainstream Western-centric culture, in contrast to Pasifika cultures, where ideologically, the collective takes precedence over the individual. This "collective consciousness" needs to be integrated into service delivery. Talemaitoga argues that "services for Pacific peoples need to be particularly adaptable and innovative to respond to Pacific peoples' varied needs and preferences" (2011, p. 168).

Pulotu-Endemann uses Pacific worldviews to develop a Pacific-specific health model. The Fonofale model uses a Samoan *fale* or house, with the roof (seen as the shelter of life/culture), beams (values and beliefs) and floor or foundation (family) encapsulated in a circle to describe the philosophy of holism and continuity. The model was used to illustrate the many health complexities from a Pacific worldview, how they are interconnected, and how they

contribute to an individual's wellness (Pulotu-Endemann, 2001). The development of Fonofale has enabled a better understanding of what contributes to Pacific health and has been compared to the similar dimensions of Te Whare Tapa Whā. Both models of health, Fonofale and Te Whare Tapa Whā, are predicated on the fact that although relative cultural values and beliefs are present, there are still differences in wellness between varying ethnic groups.

While recognising Pacific peoples' diversity, the research confirms that cultural views, language and history impact how Pacific people interact with health services in Aotearoa (Foliaki, 2002). These have been the determining factors for positive outcomes in interventions for Pacific peoples (Barwick, 2000).

Pacific Collectiveness

Collectiveness is a prominent theme amongst the literature covering Pacific health and this is shared with many Indigenous people (Kolt et al., 2006; Talemaitoga, 2011; Gordon et al., 2013; Low, 2014). The study by Kolt et al. (2006) identifies that Tongan men's physical activity usually centres around traditional living methods. This study applied a descriptive qualitative approach to learn the perceived barriers to participation in physical activity by older Tongan adults living in New Zealand. The researchers report that the idea of 'social togetherness' typically improved participation and was viewed as a substantial benefit of physical activity interventions. The social aspects of working towards the common goal of being physically active made participation more enjoyable.

Communal relationships contribute significantly to Pacific people's social prosperity and sense of wellness. Being amongst one another is the norm for Pasifika and is a big part of being a Pacific Islander. Low (2014) observes that Pacific Islanders are socially and morally obliged to spend extensive time, money and energy towards activities that promote being together. Ceremonial events and church activities are central to community lifeways and reinforce a sense of collective connectedness.

Religious Centrality

An emphasis on spirituality and the significance of church for Pacific people is embedded throughout the literature. Churches are well-attended organisations within Pacific communities, and a study from 2013 reveals that up to 97% of the Pacific population in Aotearoa have an affiliation with a Christian religion (Dewes et al., 2013). Churches have been a pillar for many Pacific people and have provided a space to promote spiritual guidance and a place of belongingness (Dewes & McColl, 2015). Thomsen et al. (2018) mentioned the church as a place for Pacific people to collectively meet, nourish traditional practices and contribute to a greater

sense of cultural identity. The abundance of ethnic-specific churches across New Zealand indicates the importance of religion for Pacific communities (Thomsen et al., 2018).

Although church-based activities have much-discussed benefits for social and spiritual health, they also may be a contributing factor to obesity and lower quality of physical health. Gordon et al. (2013) explores the role of sport and its relationship with churches. In most cases in this study, church-attending Pacific communities would commit not only their Sunday but every night of their week to church-related activities, leaving little time for other recreational activities. This research's consensus highlights the priority of church and how it often affects diet and physical exercise. Dewes et al. (2013) recognises that poorer physical health of church attendees is highly influenced by less healthy food options, lower physical activity levels, and limited knowledge of the risk factors for obesity.

Improving Health Interventions for Pacific People

To address these issues, researchers have explained that healthcare service providers should focus on working with ministers and other people of influence in the church to help change Pacific behaviours and mindsets (Gordon et al., 2013; Dewes & McColl, 2015; Thomsen et al., 2018). The influence of people with social status is explained by McLaughlin and Braun (1998), who describe the traditional social structure of Pacific society as hierarchical. Dewes and McColl (2015) believe that using figures already established as authoritative would be a way to capture specific ethnic groups.

Talemaitoga (2011) contains similar recommendations as Dewe and McColl (2015), and further asserts the need to integrate relevant cultural knowledge into healthcare practices. An analysis of Pasifika health statistics and supporting literature enabled Talemaitoga to conclude that health services should work across other sectors, such as education, housing, and social development, to better understand the factors that influence Pacific communities' life quality.

Moving Forward

Participation in healthcare services helps prevent long-term conditions and promote life quality. In most cases, interventions have been designed to cater to specialist groups, such as older adults. According to Keogh et al. (2014), participation within healthcare interventions would benefit elders. A study conducted by Hamlin et al. (2016) supports the involvement within interventions. The research shows that adherence to the studied health initiative provided long-term effectiveness in improving physical activity with older participants.

Throughout Aotearoa, the development of health interventions is a commendable approach to resolving health disparities and improving an individual's wellness. However, health inequities for Māori and Pacific communities still persist. Participation levels in health interventions are low for Māori and Pacific people. To address this, healthcare service providers should aim to integrate Māori and Pacific knowledge into the design of health interventions. Understanding what contributes meaningfully to wellness for Māori and Pasifika may improve the development of health interventions, to better engage specific ethnic groups.

There are common themes that highlight similarities between what is important to Māori and Pacific communities, particularly family. The notions of cultural collectively and community are prominent. However, the research also displays notable differences in what is necessary for Māori and Pasifika health.

The potentiality of cultural beliefs and values has an impact on health and wellbeing. Whakapapa, tikanga and the relationship to the whenua are construed as important contributing factors to improve life quality for Māori. At the same time, Pacific research emphasises the importance of religious centrality and its implications for Pacific communities.

The main takeaway from this research indicates that ethnic divergence affects the perspective of wellness. Further research to establish what is essential for wellness to Māori and Pacific communities is needed to further improve health interventions. In particular, the understanding of Māori and Pacific realities needs to be acknowledged, which will contribute to an improved sense of wellness.

Chapter 4: Research Design and Methodology

In this chapter, I discuss the research design underpinning the thesis. Being of Māori and Samoan ancestry, I draw from both te ao Māori and fa'a Samoan worldviews. The basis of my ethnic duality informs the research inquiry within a Kaupapa Māori paradigm. The research employs qualitative research methods, actualised through semi-structured interviews and a Case Study Approach methodology.

As explained in Chapter 1, the impact of COVID-19 shifted the original intent of the study, which focused exclusively on kaumātua Māori. The first Auckland lockdown in April 2020 coincided with the interview schedule planned with eight kaumātua at my hau kāinga, Tāhuna. This was extremely frustrating, because the restrictions on travel forced the cancellation of marae-based interviews. Because participants are elderly, online video conferencing, such as Zoom, was not an option; neither would telephone interviews work well for this cohort. Changing the research site to Auckland was the only option, given the uncertainties of living with COVID-19.

Incidentally, my extended Samoan *aiga* (family) were not impressed when they became aware that the original research design did not include them. However, if there is a positive aspect to the impact of COVID-19, it is that Pacific participants have added another dimension to the research.

The methodological challenge involved extending the scope of the study to include Pacific and kaumātua Māori participants (of any tribal affiliation). Initially, the research focus was a case study of Ngāti Paoa kaumātua.

Research Paradigm

Paradigms are the processes and practices that guide the research. According to Crotty (1998), paradigms are characterised through their ontology (nature of reality, what's out there to know), epistemology (nature of knowledge, how we know what we know), and; methodology (how to acquire the knowledge and the methods that will be used). Critically, these three terms create a holistic view of how we perceive knowledge, how we position ourselves concerning this knowledge, and the methodological processes we use to interact with it (Scotland, 2012).

Initially using a kaupapa Māori framework, this research also includes Pacific ontology and epistemology. The fact that both participant cohorts are Polynesian made this less challenging than first imagined. An example is "the deep respect Samoans have for the elderly or the process

of achieving consensus within a village fono (meeting)" (Tavana, 2002, p. 20). This approach resonates with traditional Māori attitudes to the elderly and tribal decision making. However, the philosophical worldview of both is shared with most Indigenous peoples.

This research uses a holistic approach to address the totality of the person, especially taking care to address their spirituality and sacredness of their customs and traditions. In other words, beyond addressing the body, mind and social dimensions of a person is the need to locate these within their familial, ancestral, environmental and divine connections. In the Samoan context, these connections are embedded in associated cultural imperatives traceable to the practices and functions of fa'a Samoa, or the Samoan way of life (Seiuli, 2012, p. 24).

The reference to fa'a Samoa is a reminder while there are similarities between Polynesian values, there are also differences. For example, the essence of family is arguably the most common shared point of interest across all Polynesian groups. However, the constitutions of what contributes to family are perceived differently.

This study integrates methodological triangulation underpinned by a kaupapa Māori paradigm, with philosophical deference to fa'a Samoa. The non-Indigenous methodological approaches are qualitative research interviews contextualised within a case study. However, indigeneity guides all aspects of this research. Various qualitative methods for data collection and analysis provide a more synergistic and comprehensive view of a particular focus (McGloin, 2008). This involves using multiple approaches to analysing data to enhance data saturation (Fusch et al., 2018).

The narratives provided by kaumātua Māori and Pasifika elders through interviews are integral, as the data analysis uncovers, validates, and improves current knowledge and thinking. Implementing qualitative research tools is appropriate because it is more suitable for the nature of this study. It allows a place for kaumātua/Pacific elders to present their lived realities and a platform for their voices to be heard.

Case Study Approach

In addition to interviews as a qualitative research tool, I employ a case study research approach.

According to Harrison et al. (2017), this is up-close, in-depth, and sophisticated analysis of a particular subject of study. It is a versatile form of qualitative inquiry and is most appropriate for a comprehensive and holistic investigation, to better understand complex issue or phenomena in context (McGloin, 2008). Case study research is primarily exploratory and explanatory, and it is used to better understand a topic in a real-life setting. It is recommended to

answer ‘how’, ‘why’, and ‘what’ research questions (Harrison et al., 2017). Crowe et al. (2011) maintain that there are multiple approaches to case study research.

Stake (1995) identifies three forms of case study theory: intrinsic, instrumental, and collective. The intrinsic case study focuses on investigating the case itself as the primary focus (e.g., person, group, and organisation) and is guided by the researcher's genuine interest in the study. In an instrumental case study, the case is of secondary importance; the emphasis is placed on the specific issue, building a theory or redefining a generalisation (Mills et al., 2010). Finally, a collective case study explores multiple case studies to identify similarities or differences (Baxter & Jack, 2008). Mills et al. (2010) believe that the integration of all forms can strengthen findings.

Accordingly, this study integrates the different approaches based on triangulation, allowing insight into multiple perspectives.

Methodological Approaches

Kaupapa Māori and Fa'a Samoa

Kaupapa Māori, according to Jackson (2015), is defined as the 'the Māori way,' and it provides an appropriate platform to investigate te ao Māori (Māori worldview). This approach utilises Māori tikanga (methods), processes, and philosophy to construct the research design and help better understand research outcomes significant for Māori (Curtis, 2016). The development of kaupapa Māori as a research methodology responds to the history of colonisation in Aotearoa, New Zealand, and the ongoing concerns about Western-centric processes and practices that have proven to be culturally inappropriate for Māori (Bishop, 1998).

According to Bishop (1998), traditional research approaches have misinterpreted Māori understanding and ways of knowing by generalising, amalgamating, and commodifying Māori knowledge. Consequently, these processes have misrepresented Māori realities, thereby denying the authenticity of the Māori voice. As a result, there is a lack of trust and suspicion with research by Māori communities (Jackson, 2015). Cram (2017) explains kaupapa Māori as an Indigenous approach that reclaims power over how Māori are represented within research and control of Māori knowledge.

Kaupapa Māori research is the enactment of kaupapa Māori theory within the academic context–it seeks to understand Māori, as Māori. It is described by Smith (2012) as an aspirational approach or methodology that integrates both practice and critical analysis. Hiha (2015) argued that researchers must have the cultural knowledge to correctly interpret and

legitimise the experience of those participating in research. The accurate portrayal of Māori is essential to help establish and redefine Māori understanding. Cram (2006) contends that kaupapa Māori researchers have a responsibility to affirm the importance of Māori self-definitions and self-valuation, and help re-conceptualise colonial constructions and definitions of Māori. Denzin and Lincoln (2005) confirm this idea by stating that research by Māori, for Māori and, with Māori is the political endeavour towards social change.

Kaupapa Māori methodologies mean that the use of Māori normalities is integrated into the research process. Fa'a Samoa methodologically intersects within the kaupapa Māori approach applied to this study. However, this study relies on a holistic, relational approach that captures the culture of Māori and Samoan elderly and respects the cultural integrity of both.

The concept of fa'a Samoa is usually interpreted simply as the 'Samoan way,' in keeping with and according to Samoan customs and traditions. However, amidst the Samoan communities in the diaspora, variant models of fa'a Samoa have emerged, yet all claim to be based upon fa'a Samoa (Siauane, 2004, p. 1).

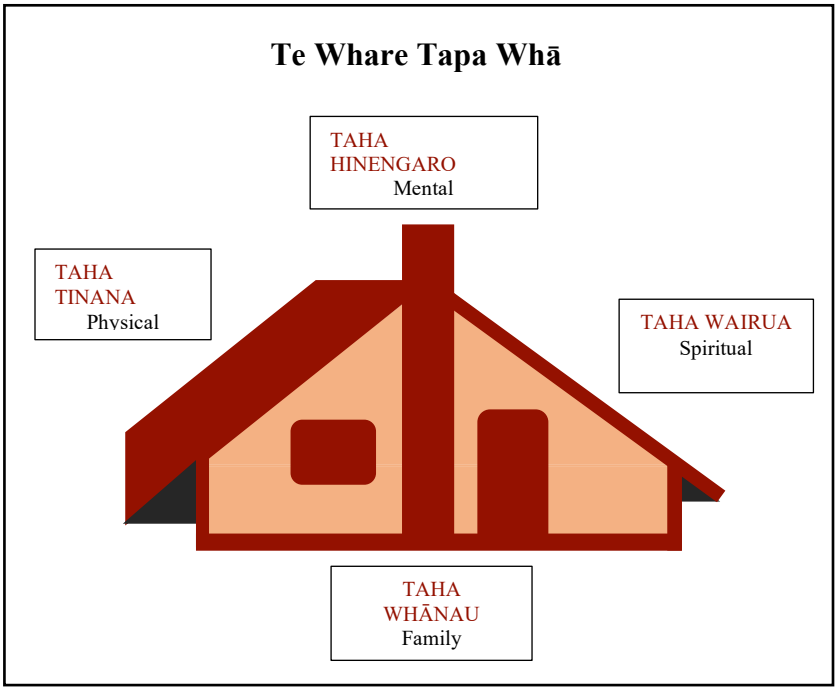
Both kaupapa Māori and fa'a Samoa approaches are evolving as academic research tools and, as such, are subject to different definitions and interpretation. The use of both is integrated into this research.

Because of the ontological parallels between the Māori and Samoan worldview and the wellness research inquiry: engaging kaumātua Māori and Pasifika elders in health intervention programmes in urban Auckland, Te Whare Tapa Whā and Poutu models can be used as a paradigm to frame the study.

Te Whare Tapa Whā

Figure 11

Te Whare Tapa Whā Framework



Note. Diagram by author.

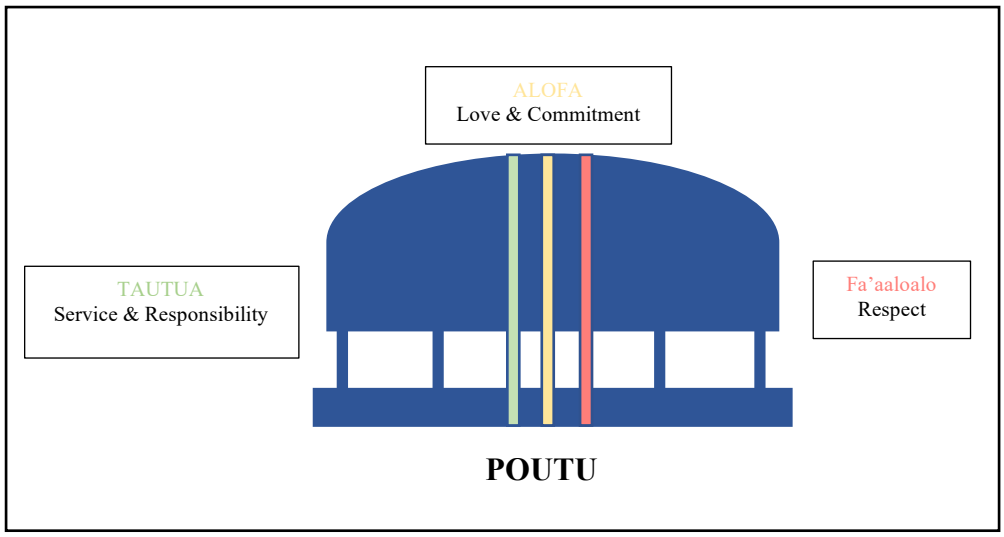
Te Whare Tapa Whā framework is a holistic concept that considers four dimensions relevant to Māori health: Te Taha Wairua (spiritual health), Te Taha Tinana (physical health), Te Taha Hinengaro (mental health), and Te Taha Whānau (family health) (Rochford, 2004). Te Whare Tapa Whā provides a helpful way for Māori to understand wellbeing as a whare. The whare has four walls, and each wall symbolises a different dimension that is believed essential to sustaining good health and wellbeing. If any of these dimensions are deficient, this will negatively impact the whare as a whole. Therefore, all four aspects of Te Whare Tapa Whā in balance and symmetry represent good health.

Poutu

Much like Te Whare Tapa Whā, the Poutu model is an Indigenous paradigm developed to contextualise the Pasifika worldview better. Podmore et al. (2006) contend that the success of Pasifika research is determined by the design and processes informed by Pasifika values. The values are illustrated in the Poutu model shown in Figure 12.

Figure 12

Poutu Framework



Note. Diagram by author.

The model is a values-based paradigm that captures the essence of 'being' Samoan. The pillars of the fale (house) articulate the fa'a Samoa way. The philosophy can be described using the metaphor of the fale and the *poutu* (posts at the centre of the fale). Each centre-post represents a value significant to the Samoan culture: *alofa* (love and commitment), *tautua* (services and responsibility) and *fa'aaloalo* (respect). Just as the poutu need to be fixed and stable to uphold the fale, so do the values.

For the diasporic Samoan, being Samoan is an absolute right, and the Poutu model is applicable as it exemplifies the independently intertwined values that are embedded in any person of Samoan descent. Liki Chan Tung (2015) further elaborates on the essence of being a Samoan:

> One is born as kin and remains as kin regardless of one's changing circumstances in life… kin… defines belonging and underpins rights and access to support and resources within the kinship network. The relationship also guarantees economic and social security… e malu ia te oe 'āiga, e malu foi oe I 'āiga [you carry 'āiga and 'āiga carries you]. (p. 130)

Research Methods

Geneology: Whakapapa and Gafa o Samoa

Genealogy is the core of traditional Māori and Samoan epistemology and a significant factor in establishing identity. *Whakapapa* means to place in layers, such as cultural concepts or genealogical connections (Barlow, 1991). The language and practices of our ancestors are embedded in history and our land, which expresses the link to our origins; to understand the future, whakapapa recalls the past and examines the present-day (Ka'ai & Higgins, 2004). Whakapapa (genealogy) illustrates how we are connected; it enables Māori to make sense of the relationships we share with the environment, people, and the gods (Reilly, 2004). The integration of *whakapapa* into the study is crucial because it solidifies cultural identity and relationships. *Gafa o Samoa* (Samoan genealogy) fulfils a similar purpose for Samoan participants. The understanding of whakapapa/gafa o Samoa benefits both the researcher and the participants. The many relationships that connect us create this platform of research.

Adhering to fa'a Samoan (the Samoan way) is closely associated with gafa. For many Samoans, sharing one's genealogy is important, as most identify through their families and ancestry. The importance of genealogy for Pacific people is exemplified in the historical story of Nafanua, the ali'i (chief/queen) and toa (warrior) of Samoa. Nafanua is known amongst Polynesians as the Goddess of War, who brought peace to Savai'i through her heroic military victories (Lesuma, 2019). Gafa has been recognised as the source of her physical, spiritual and political power; most interpretations of Nafanua's triumphs begin with acknowledging her parents and often her grandparents.

Whānaungatanga and Fa'aaloalo

Māori and Pacific models often emphasise the importance of connection and reciprocity; for Māori, this is exemplified in the concept of *whānaungatanga*, whereas, for Samoans, this would be more closely aligned to *fa'aaloalo* (respect).

Whānaungatanga is significant in te ao Māori and refers to the sense of family connection and belonging; it is established through relationships, shared experiences and working collaboratively (Mackay et al., 2019).

The concept of fa'aaloalo is engrained within protocols and traditions and, more specifically, is arguably the most significant pillar that upholds the value of fa'a Samoa. The respect presented to others, especially elders, is important; how you interact with others reflects your aiga/gafa. Fa'aaloalo is viewed as the first building block towards connection to other Pasifika people.

Whānaungatanga and fa'aaloalo within the context of this research was applied across all applicable areas:

1. I informed board members of Waiti marae about the research and its purpose.
2. Elders who opt to participate in the study were given a preference of interview location, allowing for an environment they feel safe.
3. I employed semi-structured interview questions to help guide the interview. The use of prepared questions allowed participants a platform for open-ended responses, for more in-depth information.
4. *Koha* (a gift) was given to each participant to acknowledge their input and collaboration within this study.
5. All participants within this research were given a copy of this work, so that they had a physical representation of their contributions.

Kanohi ki te Kanohi and Kanohi Kitea

The term *kanohi ki te kanohi*, translated from te reo Māori means 'face-to-face'; more specifically, it refers to physical, in-person engagement with others. *Kanohi kitea* is a similar concept, meaning 'the seen face', highlighting the importance of a physical presence. Kanohi ki te kanohi and kanohi kitea work harmoniously to help establish and strengthen relationships (Bishop, 1996).

The value of relationships is an integral part of Pacific culture. Predominantly, Pacific people are raised with a communal living standard, and the significance of social engagement is high. Therefore, using kanohi ki te kanohi and kanohi kitea within the context of this research is suitable, as it empowers relationship development for the study.

Time spent with participants before the interviews was focused on more general and meaningful interactions. Establishing a prior relationship allowed participants the opportunity of freedom to share and retell their stories with someone that they feel comfortable with, and someone willing to listen to their experiences.

Qualitative Research Methods

Qualitative research is a systematic inquiry that strives to create a holistic, primarily narrative, description to inform the understanding of a phenomenon (Azungah, 2018). The Indigenous theories operate similarly, and, in particular, the analysis process is not reliant upon the quantity of data collected, but rather the quality and the content.

According to Johnson and Christensen (2012) and Bansal et al. (2018), qualitative researchers try to study the world as it naturally occurs–without deliberate addition, manipulation or transformation into efficient data display. A strength of qualitative research is the flexibility of the process; this allows researchers to respond to newly discovered knowledge as it emerges (Kirk & Miller, 1986). This is appropriate as it is more empowering for research participants and applicable to society's evolution (Walker et al., 2006), thus giving kaumātua/Pasifika elders the ability to share their worldviews.

Johnson and Christensen (2012) propose that qualitative researchers view human behaviour as dynamic and subjective; they recommend in-depth analysis over a reasonable period to best understand phenomena. The approach focuses on the narratives of people by looking at their first-hand experiences, documenting detailed descriptions and progressing through a series of steps toward completion (Azungah, 2018). Following these steps allow researchers to focus on an individual's behaviours, opinions, and emotions. Merriam and Tisdell (2016) indicate that qualitative inquiry aids in identifying people's beliefs and understandings of phenomena. This view is expanded on by Creswell (2003):

> Humans engage with their world and make sense of it based on their historical and social perspective–we are all born into a world of meaning bestowed upon us by our culture. Thus, qualitative researchers seek to understand the context or setting of the participants through visiting this context and gathering information personally. They also make an interpretation of what they find, an interpretation shaped by the researchers' own experiences and backgrounds. (p. 9)

Overarching the qualitative research methods are the principles of Indigenous and Pacific research methods. The use of varying qualitative methods is becoming more prevalent in research with Māori and Pacific populations. Adopting qualitative measures with kaupapa Māori theory and Pacific frameworks has been pivotal in providing an appropriate methodological approach for research with Polynesian people. Barnes (2000) maintains that qualitative research methods are suitable for Māori research. Qualitative methods allow Māori to explain phenomena in their perspectives, through their lived experiences and worldviews (Dyck & Kearns, 1995). This provides a platform for Māori and Pacific views to be heard, and allows for equal participant empowerment.

Data Gathering Methods

This research was conducted in Tāmaki Makaurau, Auckland, with Māori and Pasifika elders. Six elders participated to address the research. The age of the participants ranged from 60 to 90 years.

Semi-structured interview questions was used to guide discussion with kaumātua Māori and Pasifika elders. The actual interviews took into consideration cultural beliefs and values. During the interviews, whānau/aiga were welcome to be present in the interview space. Elders were offered refreshments, and the interview process began and finished with a prayer.

Research participants were encouraged to share their views on mainstream health programmes, wellness, valued activities in advanced age, and their response to COVID-19.

Research Questions

To understand how to engage Māori and Pacific elders, it is important first to learn their idea of wellness and what informs their participation in health-related activities. Additionally, knowing their responses to COVID-19 will provide a good insight into the severity of the pandemic and its implications for the health of Polynesian elders.

The questions below will provide a platform for participants to share their views towards wellness. In addition, their experiences with health programmes and their perspective on what services are needed within their community will be documented.

1. How would you describe Māori/Pacific health and wellbeing?
2. As an elder, how does a Māori/Pacific idea of wellness help you to be healthy?
3. What about your physical health?
4. What programmes to help with your wellbeing have been offered to you by your GP or other health professionals?
5. What stopped you from participating?
6. What kind of programmes do you think our community needs to help support older adult health and wellbeing?
7. How has COVID affected your health and wellbeing?
8. Have you been able to exercise, and if so, what sort of exercise have you done under COVID lockdown?
9. Is there anything, such as additional supports, that would have made COVID lockdown easier?

Data Analysis

Thematic Analysis

The process of thematic analysis was used to interpret the narratives of kaumātua Māori and Pasifika elders who were interviewed.

Thematic analysis is a widely-used method that is common in qualitative research. This method aims to identify patterned meaning across a dataset (Scharp & Sanders, 2018).

Braun and Clarke (2006) provide a six-phase process that helps conduct this form of analysis:

1. Familiarisation with the data: reading and re-reading the data to be thoroughly familiar with the entire body of data.
2. Generate code: organise data in a meaningful and systematic way.
3. Search for themes: examine and collate relevant codes into 'potential' themes.
4. Review themes: review, modify, and create the preliminary themes, then identify if the themes make sense within the research context.
5. Defining themes: an in-depth analysis of each theme, identifying the 'meaningfulness' of the theme and the aspect of data it captures.
6. Write-up: produce the analytic narrative and contextualise the analysis with existing literature.

Conclusion

In conclusion, kaupapa Māori theory informed by Pacific ontology and epistemology underpinned by qualitative research methodology provided an opportunity to apply a critical lens working with kaumātua Māori and Pasifika elders. This chapter discussed the use of Te Whare Tapa Wha and Poutu, which is of great importance to this thesis due to the practical parallels of kaupapa Māori and fa'a Samoa ontology. Furthermore, a case study approach was used to guide the research enquiry.

Chapter 5: Results/Findings

This chapter gives voice to the participants. They are able to give substance, in their own words, to the research question; *What are the barriers to Māori and Samoan elderly participation in mainstream health services?* The research question is contextualised within the broader framework of the paradigms which frame this study.

The analysis of the information gathered from the questions is organised according to the group headings: (a) what is Māori or Pacific wellness?; (b) what contributes to Māori or Pacific health and wellbeing; (c) what are the key challenges towards accessing healthcare services; and (d) how has COVID-19 affected wellness? The data is analysed according to the questions, and the themes grouped according to five categories, as follows:

Theme 1: Whānau and aiga
Theme 2: Motivations for wellness
Theme 3: Barriers
Theme 4: Healthcare services
Theme 5: Covid-19 response

These five overarching themes were used to refine the analysis of initial themes further. The five themes are aligned with Te Whare Tapa Wha and Poutu frameworks. The findings of the interviews are compared with the values that inform Te Whare Tapa Wha, as a basis for addressing the critical research question. Each heading covers two to three individual questions discussed with each participant. The material from participants was selected based on the most relevant responses that address the questions, to provide deeper and more meaningful understanding and insights to each overarching question.

Six older adults aged 61 to 83, from relatively diverse backgrounds, contributed to this part of the research. While originally from different geographical areas, they resided within Auckland and have adjusted to an urbanised lifestyle.

Table 2

Interview Participants' Demographic Profiles

Participant	Tribal affiliation/ Ethnicity	Gender	Age range	Occupation
A	Ngā puhi, Ngāti Porou, Ngāti Kahungunu and Ngāi Tahu ki Mohaka	Male	60-70yrs	Senior Consultant and Principal Advisor Māori
B	Ngāti Pāoa	Female	60-70 yrs	Teacher's Aide
C	Ngāti Hako and Ngāti Paeahi	Female	80-90 yrs	Retired
D	Leulumoega (Samoan)	Male	70-80 yrs	Retired
E	Fagamalo (Samoan)	Male	60-70 yrs	Factory Supervisor
F	Safune (Samoan)	Female	70-80 yrs	Retired

Theme 1: **Whānau and aiga (family)**

The essence of 'family' and what contributes to its livelihood had an essential role in wellness. When asked about wellness from a Māori and Pacific perspective, the respondents tended to speak about their families as a key priority. Participant A summarised well the shared value of family, which was prominent amongst all respondents.

> *So you got big iwi orientated things, but for me, the most core component for oranga* (health) *for Māori sits within their whānau unit.*

All participants agreed that various constituent parts inform this view. An unsaid but strongly evident element was the accountability needed to uphold the perceived responsibilities of an elder of the family. Participant A further elaborated his idea of whānau and the specific role he plays as an elder within the family dynamic.

> *When you think of the notion of a whānau which is to be able to collectively provide support and be interdependent in that space and still do your own things but at the same time knowing you need to contribute to the wellbeing of the family.*

For him, the awareness and management of his health indicated the ability to actively contribute to his whānau's wellness. Likewise, Participant D acknowledged that his idea of 'good health' interrelates with providing for the family.

> *Good health means you can look after your family. If you are healthy, then you can provide for your family, for your children, your grandchildren, and your extended family.*

The narrative of poverty and the cycle that causes intergenerational trauma was the basis of what informs the need to provide a better life for the family. Participant D mentioned that his ability to provide was a way to give his children a promising future. He believed his contributions were a way of breaking the cycle.

> *Sometimes if you are sick and you stay home for a week, then that means that there is no income, and that will affect your family. It will affect your grandchildren. It is very important for a Pasifika person to know that.*

The importance of 'family' was said to have been ingrained from an early age. More often than not, the respondents elaborated that valuing family was an integral part of their culture. Most of the participants recalled always giving priority to family-related activities, as it was the "Polynesian way." Participant C firmly believed that understanding a family's importance is a fundamental part of growing up in a Māori household; she contended that this view was instilled in her at an early age and had positive implications in her older age.

> *It starts from the beginning and works its way up. If our children are educated and understand, so will it be. I'm very fortunate with my tamariki* (children)*; they are always around me.*

It was evident that the importance of family was always significant throughout a Māori or Pacific person's life; however, it seemed to be heightened in advanced years. Participant E acknowledged a shift in his worldview when crossing over into an older age range; the emphasis on putting others before himself was of the highest importance.

> *It's not about me now; it's about putting other people before me, like our extended families, our uncles and aunties, and our grandchildren and great-grandchildren. I really care about them.*

The Foundations

The value of family was often informed through life experiences and upbringing at home. What was prominent amongst most of the respondents was the 'passing of the baton' mentality. The family dynamic and the responsibilities of each role were learnt throughout life. Participant A highlighted his parents as the role models that guided his knowledge of duties for his family.

> *When we went to visit the kuia in the hahei, some of them only spoke Māori and I didn't know what they were talking about. I would go with my dad, and he would do the manaakitanga* (hospitality). *Mum and dad would always go to the tangi. I didn't think I would ever need to go to tangi, but when they died, guess who suddenly went to tangi* (funeral)*? Guess who's talking about the importance of koha* (offering)*, reo* (language)*, and whakapapa* (genealogy)*?*

Participant B had a similar viewpoint. Her decisions relative to the health of her whānau have been heavily influenced by the example set by her experiences growing up. She referred to her father to exemplify the role of a parent and leader. In particular, her approach to managing sickness with her family is informed by her father's past actions.

> *..and how he cared for us when we got sick, it was always off to the Pākehā doctor and not the Māori doctor to get the medicine and fix the problem up. It was like that for us for all of his life. We came first because he knew with the sickness that he had if it can be taken care of, rather than just letting it be and getting worse.*

The Body Ages, but the Foundation Remains the Same

Participants were aware of the natural physical implications that came with ageing. They report that physical barriers hindered their ability to do the things they were usually familiar with, as they got older. In light of this, most participants spoke about their shift in priorities. For example, participant A noticed his priorities changed after his fifties.

> *The things you enjoyed or wanted to do when you were younger starts to get lost as you age. Priorities start to change; you get a wife, family, cars, house. After you hit your 50s or 60s, you start signposting what will be physically in the journey for you.*

With an understanding of physical bodily regression in older age, Participant A shifted his focus to relationships as the priority leading into his sixties. An interesting point from his elaboration of the value of relationships was his ideology of happy relationships.

An important thing is relationships. If you look at people that are happy often, it is because their relationships they have reached a point where there is a solid balance of respect for the roles of a māreikura wahine woman or a whatukura tane the mana.

The regression of physical ability in older age wasn't entirely viewed negatively. Participant C was mindful of her disabilities and the impact it has had on her wellbeing. In her later years, her reliance on her family has increased. However, she said she was content with her life and found happiness in her family.

As we got older, I don't have the same sting as I had before. But I'm happy. My whānau is what made me happy.

..I usually get up and do that with my daughter instead. I'm blind, toothless, deaf, I have a pacemaker, and I have arthritis.. But I'm happy.

On the other hand, Participant B was more conscious of the demands of being dependent on her family. Her independence was a way of alleviating possible stress so that her grandchildren could be the primary focus of her children.

My boys have their own lives, and I don't want to encroach on that because to me, their families are more important. I come second, always have.

The majority of the participants echoed that same idea that the concept of family was significant in their life. In most cases, the family's livelihood was indicative of what contributed to their wellness. For example, participant B spoke of her grandchildren, and she firmly believed her happiness depended on their livelihood.

Whatever they do, as long as they're happy. As long as my mokos are getting fed and they have a roof over their heads then I'm all good.

Whānaungatanga – Being Amongst Others

A solid collective orientation was evident throughout all participants, whether with immediate family, extended family, or friends. The idea of being amongst others was normal. However, participant E had a different approach from most. He specifically mentioned how engagement with others directly improved his ability to be healthy. The importance of the church and a relationship with God informed this view.

Being engaged with other brothers and sisters, family and friends, and putting people first before me.

His experiences growing up in the church taught him the value of serving others. The Samoan proverb "O le ala i le pule o le tautua" was a critical idea that informed his worldview. It is translated as "to lead, one must serve." Participant E believed that the grace of God would honour prosperity and good health to those who serve well.

For me, it's my background, and my life is that I value people; that's how God sees people.

For some participants, the traditional definition of 'family' was perceived as sometimes superficial. They spoke about their time with others irrespective of their genealogical ties. The collaborative efforts of being together or working towards a similar purpose gave a sense of fulfilment. Participant A elaborated on his engagement with recreational group-oriented activities. He found that being among others with the same interests was an excellent way to develop relationships and keep him accountable for his exercise goals.

I'll be 64 next year. I'm with a group of people who do the running, there are seventy plus year-old wāhine,, and I think cool! It's another role model space.

A group where we share common interests about our own exercise. We meet up to go for a hikoi (walk) *or a run. We post every day. Build relationships with other people, working towards the same kaupapa* (purpose).

Participant C agrees, and she firmly believes that being in others' company is indicative of sustaining a happy and meaningful life. She reflected upon some of her favourite activities; all involved a form of social engagement.

..elders enjoyed being amongst others, sitting on the floor playing cards

I did activities with Māori and Pākehā. It was once a week. It was good. We need others company. If you don't have fun at your age, you'll be a bloody misery.

Throughout all interviews, the essence of the family was woven into the respondent's answers, and it was, for most, the reason to optimise health in older age.

Theme 2: **Motivations for Wellness**

When prompted with the question "How would you describe Māori/Pacific health and wellbeing?" the concept of health was perceived differently by almost all participants. Some identified specific aspects relative to the physical dimension, while others referred to health as a more holistic concept.

Participant E explained his view on health as more physical. In addition, he expressed an emphasis on exercise and healthy eating.

> *For me, wellbeing and being healthy is eating the right food and doing a lot of exercise. I do a lot of walking, not so much of running now, but a lot of walking.*

This view was shared by Participant F.

> *Yes, like no carbs, you know, no fat food. Healthy food, like fish, lean meat, vegetables, and all that. I hate taro; it's too much starch.*

Both participants agree that their view on health and being healthy indicated a person's body composition. However, one participant challenged this view and shared his perspective on his thoughts. He believed a deeper mental consciousness needs to be present in individuals to be in a healthy state.

> *Sometimes when we think of oranga, everyone thinks of the physical component all the time. The first thing is you have to be comfortable with what you look like, look inside yourself and ask yourself. I dislike when people ask, "can you see a skinny person inside a big body", why don't they see someone inside that person who is healthy instead. You don't have to be like me, and I don't have to be like you. But we can live in a way that allows us some control over what's happening for us, and that is wairua* (spiritual) *thing for me. That is ngā kare ā-roto; it is your inner thoughts.*

The view of what defined health was vast; however, predominantly, participants were familiar with the general benefits of maintaining their health in older age. There was a shared understanding that good health equates to a higher quality of life. Each person had their own approach to optimising their wellness.

Most participants used walking as a platform to help manage their physical health. Participant D spoke of his routine activities; walking in the park or along the beach with his wife was one of their daily rituals.

> *I love walking; I look forward to it. I don't need to run; my bones can't. The easiest thing if your wife can't go, go in the car to the park… And my wife really loves walking now. Because I encourage her to walk, it's good for yourself. It really helps you. It helps you to sleep at night.*

Similarly, Participant F walked every day to the local cemetery to visit her late husband. Again, she expressed a sense of joy and peacefulness being in the space of her significant other.

> *Every day I walk to the cemetery.*

What seemed important amongst most was not the physical movement involved in walking or running but the experiences gained during the activity. Participant A credited the environment to be one of the main reasons attributed to walking enjoyment. He specifically mentioned the impact of mental stimulation.

> *For me, when I am in the taiao* (the natural world)*, there is just so many things to see, opportunities to be able to stimulate the mind in the activity.*

Doing What is Important – Cultural Connectedness

In conjunction with mental stimulation, Participant A further identified activities that aid in bettering his overall wellness. He believed that wellness was the amalgamation of various dimensions: physical, spiritual, mental, and social. All were reflective of the Māori health model, Te Whare Tapa Whā. For him, the sole focus on the physical was not significant; it was only part of a bigger picture.

> *I reckon as I've gotten older, it is not so much about how to heal something; it's more preparation and mind around what really is important to me.*

> *I'll do things that are important for me now, and not just consider that when you have a break, you go on holiday. I will get on my bike and go for a ride with my mates, with all the whanaungatanga that we have, all on the same kaupapa; or go diving with my sons amongst my wife's papa kāinga* (home)*, cooking the kai* (food) *over a fire and stuff like that, and the rongo* (healing) *I got from that was far better.*

Apparent in the feedback of the participants was the importance of particular places. Some participants would often refer to sites like the marae or *papa kāinga* (home) to contribute to their wellness. Participant C highlighted returning to her marae as a frequent expedition. In light of her disabilities, she was aware that the marae offered a unique connection. She was able to connect with others and get back to the land she was from.

> *...the girls have to take me home. We go back to look after the Marae. I enjoy going home.*

Doing it For Those Who Matter

Doing it for "my why" was a phrase that came up during the interviews. The term was said to define the reason for motivation. In the context of this research, participants would identify their children as the reason to try and optimise their health. However, their approaches to how their family motivated them were unique.

The desire to live longer to see the family thrive was a key motivator. In addition, participant E was passionate about witnessing the successes of his children. For him, his children's transition into adulthood was meaningful.

> *So I can live to see my children grow up. I want to see them have a good life. I want to see my daughter have a man, have a family, have children. I think it's good for me to have something in the future to look forward to.*

The motivations of Participant D differed, however. He felt obligated to maintain a state of ability to provide for the family—the inability to work being reflected in decreased pay. There was a priority to be able to work to ensure money was consistently incoming.

> *Sometimes if you are sick and you stay home for a week, then that means that there is no income, and that will affect your family. It will affect your grandchildren. It is very important for a Pasifika person to know that.*

From another perspective, Participant A felt a responsibility to maintain his health to educate his family. He believed that his role modelling would enable the children to navigate their health with more awareness through a holistic approach.

> *When we talk about oranga wellbeing, there are a lot of things that we do. We put up this façade, and when something hits you in the face, then you got to stop for a moment and ask yourself what is really important. What I came out with from the other end is*

> *making sure that the legacy I left behind with my mokopuna (we have 14) is that I want them to understand that they can actually hold to how they feel about themselves to make sure there is a bit of wairua oranga going on, a bit of hinengaro oranga going on, a bit of tinana oranga* (physical health) *going and not letting one of those things out focus the other, you need it combined, and that's what I've learned as a koroua* (elder) *in my years of moving on the other side of the sun around oranga, it's balance.*
>
> *If our tamariki and mokopuna don't have role models like that, then they are in deficit. Part of the task for me is setting an example for my children. I want them to chase their dreams but making sure they do it in a balanced way, showing them the way.*

Theme 3: **Barriers**

Several factors hindered participation with health-related services. For some, self-related health wasn't a priority. Other participants recalled multiple issues with their experiences that prevented their future engagement.

Participant A summarised an unsaid but shared view of most participants; he expressed that health and the generic life goals associated with what determines its success were obstructed by the implications of poor health and education.

> *There was a huge impact for me on looking at health, if we are looking at health from a Pākehā way; getting a house, a ¼ acre section, a family, a good job, but that does not equate for a lot of our whānau.*

Financial hardship was often an issue for many of the participants.

Cost an Issue

Healthcare services were often viewed as too expensive to prioritise, with many stating the money would be better spent maintaining their family's livelihood. Participant D explained his reasoning for not visiting the doctor, and mentioned he would only go if it were his last resort.

> *You can't afford to see the doctor. You got to have money. The doctor is not cheap. Your medicines is not cheap. It can all add up.*

When asked about their approach to maintaining physical wellbeing, Participant D found it hard to participate in any form of paid recreational activity for his health. A lot of the time, his family only had enough money for daily life.

You spend $10 on the gym, that $10 can make your children's lunch. You got to put extra money aside. If anything happens to you, at least you have extra money to pay rent and power bill.

Participant F shared a similar narrative. She talked about her family's struggle with poverty whilst living in New Zealand. Although she and her late husband had jobs, she was adamant that the poverty cycle was hard to break out of, as a first-generation immigrant.

People stay poor and struggle, not enough money to buy the things they want, so it should be the government that does something to help them and us.

Language a Barrier

The inability to effectively communicate with healthcare professionals was often a deterrent for Pacific elders. Some participants indicated that their lack of proficiency with the English language made it challenging to access services. This is compounded by a lack of understanding of health-related jargon. For example, participant D explained the difficulties he had with his last visit to a hospital. Communication between him and the attending doctor was problematic, and as a result, he had undiagnosed health complications that worsened and landed him in the emergency department.

Participant D went on to speak of the recent barriers preventing him from going to the doctors. The COVID-19 pandemic has made it extremely difficult for him to access healthcare services, as he must make consultations over the phone. He expressed that access is now more complicated than ever.

You want to go and see the doctor, but you have to on the phone, but you can't because your English is no good. It's hard to tell them. It's alright for me because maybe my English is a little bit better than other Pacific, but it's hard to communicate.

The Lack of Familiarity with Providers

Some participants recalled negative experiences with health professionals in the past that tainted their view of healthcare services. In some cases, participants reported feeling 'unwelcomed' and 'a burden.'

Participant D highlighted that the doctors' lack of care during consultations made him hesitant to use any related services. For example, one doctor prescribed him a complex prescription with little or no explanation. Another doctor, a few weeks later, indicated that a healthier diet and frequent exercise was the more suitable solution to address his condition. He later explained that

the contradictory prescriptions and "being passed around all the time" were his key reasons for not partaking in regular health check-ups.

> *There are some doctors that are lazy, they just give you ten pills without looking at blood tests.*

> *I stopped because they kept changing the doctor. I couldn't be bothered anymore.*

Fear of Judgement

Some participants felt uncomfortable attending mainstream healthcare services due to the fear of judgement. As a first-generation immigrant, Participant D explained his troubles with past health-related services. They were aware that their body composition did not fit society's socially constructed standards, and, as a result, they sometimes avoided going to particular health-related organisations.

> *Some people are too shy to go because they're too big. For the second generation, it's no problem. But the first generation, who come from the Pacific it's different.*

Social Isolation

One notable mention by Participant C is that she no longer has some of the significant relationships that she once had in earlier years, in her old age. In addition, a few important members of her whānau had passed on, which at times created a sense of loneliness and social awkwardness.

Participant C talked about the impact it had on her confidence in engaging in particular services. In place of limited social interaction, shyness was often an issue that deterred her from accessing specific interventions. At the time, she had social workers who supported her from day to day, but believed that they needed to be more relational to help enhance her quality of life.

> *Some kaumātua are shy and have no one. We need more social workers who talk more to actually find things out. At our age, we become disabled.*

Unaware of Services

Despite the availability of health-related information, participants indicated that they were not aware of the available services. On most occasions, participants were only referred to a service once they were severely at-risk or had already developed a condition. For example, participant C mentioned her referral to a health prevention strategy once she was already disabled.

Participant B and participant D expressed in concernment that they had never been informed of any health initiatives. What was apparent was that health-related service referrals were often recommended too late and typically offered as a tool for health condition management instead of health condition prevention.

> *The doctor hasn't advised me to be in any programmes. I never heard of that before, asking if you want to join that programme or this programme.*

Theme 4: **Healthcare Services**

Positive experiences with healthcare providers were the most significant factor that informed future participation. The level of care provided to participants in any setting was necessary for the engagement of Māori and Pacific elderly communities. Participant C spoke of the notion of *manaakitanga* (hospitality and the process of showing respect), and how it was essential for making her feel welcomed entering into any foreign spaces. She explained being with her general practitioner for over three decades. The loyalty to her doctor stemmed from the 'trust' developed through their experiences and familiarity, as she was also of Māori descent. Trust was a value that enabled her to consider and adhere to any medical advice prescribed.

> *I've been with my doctor for 30 years. She has Māori heritage. I have always stayed faithful with her. She has always helped me. I have never been without anything thanks to her. I think the best thing is knowing your doctor and having a good rapport with your doctor. If you trust the doctor, they will be there for you.*

Empathy was said to go a long way in developing trust in participants. Participant F also mentioned being with a doctor for over 30 years. The relationship with her doctor was viewed as more relational and less transactional. Her doctor had always gone the extra mile to make sure her family was well informed and looked after. She explained that her doctor was highly empathetic and encouraging during losing her husband, which helped ease the sadness.

> *Yes, and he always looks after us, he always gives me advice. When my husband passed away, he was always nice. I was going to finish* [retire] *straight away, but he said to me go to work to get my mind busy, occupied. Because if I stay home, I get sick. Because all I think is my husband and all that.*

Being well informed by health professionals was essential for most. Participant D recalled experiences in the past where he didn't feel comfortable with the advice of a doctor. Sometimes, he couldn't truly grasp the advice given due to language constraints, which would impact his

understanding of his conditions. He appreciated it when doctors would 'sit down and talk' with him. When health professionals were more mindful, he felt safe to ask questions and was more receptive to the recommended advice.

> *We trust this guy. He communicates with this us; he sits down and talks with us. He even says to us, "I can't give you pills, but at least you can do exercise", instead of getting a pill and then having to take another pill for side effect.*

Participant C had a similar view. She liked that her doctor was upfront and proactive with her health needs as it allowed her clarity and ease.

> *She was upfront. I liked that she was upfront. She would drop hints about things I should do, and it was up to me to make a decision.*

> *My doctor applies to most things for me. She applied me for 'Senior Citizens' and the Blind Foundation.*

It was clear that participants were aware that Māori and Pasifika people have different health needs. Participant D believed that health professionals need to be considerate when interacting with other ethnicities in New Zealand. He was mindful of the benefits of Western practices, although he asserts that doctors should have an understanding of Māori and Pacific health, to empower change in health disparities.

> *What we really need is a doctor that understands a Pacific illness. Europeans and Pasifika are different.*

Influence of Title

The title of a person, such as a doctor or minister, was viewed as highly influential. The advice given to participants by a doctor was often regarded as 'the truth.' In some cases, adherence to prescriptions was upheld and affirmed by a health professional's status, irrespective of treatment methods that may have contradicted personal comfort or beliefs. Participant D explained his reasons for adherence to any advice given by a doctor and credited their education and status as an influence.

> *That's why they sit this degree because he's the doctor. He knows more than you do. It's up to him to give you what you need to be healthy or get rid of that illness.*

A Whānau-centric Approach

Services that emphasized an individualized person-centered approach to health did not entice elders towards participation. Almost all participants mentioned their preference for group-based activities. Participant A spoke about his view of desirable future interventions. He highlighted that services would benefit more with a whanau-based approach.

> *I would want to do things that I am able to do. Gather in groups you know as a whānau. Activities to keep them connected. My parents, in older age, gravitated towards family-oriented activities. It might even challenge the fact that instead of doing activities for kaumātua, how about we do something that involves whānau, that ties to that.*

Similarly, other participants drew a connection to group-oriented activities. For example, Participant F mentioned that she frequently attended the community Zumba group at the local shops. On the other hand, Participant E enjoyed the idea of Buttabean Motivation (BBM), an organisation aimed at reducing obesity statistics through exercise and diet intervention. They found the group orientation of these initiatives were less intimidating and more reflective of family orientation and togetherness.

> *I like what Brown Butterbean is doing; I see people doing his programme, even 80 years. Perhaps they need more of that in the community, just to really encourage people.*

Theme 5: **Response to COVID-19**

COVID-19 prompted scattered emotions throughout all the participants. On the one hand, the lockdown's implications created fear, especially regarding family members away from home. But, on the other hand, participants enjoyed their time and used it to spend quality time with their families.

The Bad

Participants were aware of the lockdown protocols and the role they play within the community. However, their main complaints were almost always relative to issues involving the family. Not being able to see their family in person was disheartening, as was the impact of unemployment.

> *It's very hard because you haven't seen your grandchildren. It's so hard, great-grandchildren. We always have lessons together.*

It's scary; it is because when we see the TV, people die. It's really scary. Even when we had the lockdown, I hate the lockdown. Boring. Staying home. But we had to obey the rules.

One of my sons is unemployed.

The Good

Elders who lived with their families prior to the lockdown reported having more positive experiences. Participants indicated that the on-hand support of family and being together made the event more bearable. Some viewed the lockdown as a time of recovery. They mentioned the government subsidy scheme as a positive as well.

I enjoyed Covid-19. I just stayed home and listened to my discs from the foundation. It was stories about history and anything you like. It was about romance, education, magazines, musical, all sorts - a good selection. I would go to sleep with my discs playing. I had the whānau home. I didn't have to do nothing; the whānau did everything. The company was nice.

Covid has been good for me. Part of it is that I can determine work. Work from home. I enjoyed the quietness.

Prayer

Prayer was a common practice among all participants that alleviated some stress during the COVID-19 lockdown. Some participants reported praying more every day to invoke spiritual guidance and protection. The belief in prayer gave participants the courage to go about their daily activities. For example, participant E prayed multiple times a day during the lockdown. He was an avid believer that his faith was the protective cloak that guided him and his family.

My faith comes with my walk and my wellbeing that I believe that I am okay; there is somebody looking after me when I'm in the shopping mall and when I'm out and about.

The use of prayer was often entrenched by cultural traditions and was significant among most of the participants. For example, participant A spoke of karakia (prayer) and how he believed in safeguarded his journey in life. It was a practice that guided his wellbeing considerably and is a practice he now applies to protect his family.

I've been raised in a family where we had karakia all the time; we had fasting and all these traditional methods. I had these tools—the things about wairua and the

significance of it. When I was overseas for a long time, it was through the karakia from my whānau that brought me back home safely. There's transfer going on with my ōranga from my loved ones from a wairua. They did it for me. I'm doing it for my boys.

Conclusion

Māori and Pacific elderly are resilient. However, as expected, family and relationships were central to their sense of wellbeing. All participants shared a sense of responsibility for the welfare of the family. Poignantly, some referenced poverty as a barrier to providing more financial support. Although this was not stated explicitly by all the participants, it was evident that they put whānau/aiga needs before their own needs. A couple of participants expressed concern about the "burden" they may have on their family. They were acutely aware of the potential physical and mental effects of aging.

Most of the participants were very conscious of adhering to a healthy lifestyle. At the same time, one significant barrier to accessing mainstream health services was feeling judged because of body size. The barriers to healthcare services highlighted by participants can only be described as systemic racism. Some felt that Pākehā/Palagi (non-Māori/non-Samoan) medical staff were dismissive of their needs. Although this could be attributed to personalities, the attitude is unacceptable, irrespective of culture. However, for Māori and Pacific people and the elderly, perspectives are critical to patient/client engagement in health services. Given the well-known disparities in health, engaging vulnerable people in the health system is vital.

While the findings reinforce the need for the health system to do better for Māori and Pacific people, they are also depressing, considering that these disparities have been on the agenda for decades. The Ministry of Health has a statutory responsibility to advise the government on policies to reduce health inequalities, including those experienced by Māori and Pacific peoples in New Zealand (King 2000). Unfortunately, this research undertaken, in 2020-2021, shows little progress has been made in this area. However, the cohesiveness of whānau/aiga evidenced in this small survey shows that the cultural beliefs and values sustain our elderly.

Chapter 6: Conclusion

The fight to eliminate health inequities amongst Māori and Pasifika elders is still ongoing. Despite the availability of various healthcare services, the current health statistics regarding morbidity and mortality rates of older Māori and Pasifika people are not reflected positively, compared to other ethnic groups. The barriers to participation in mainstream healthcare interventions for kaumātua Māori and Pasifika elders are a challenge. Exploring their engagement in healthcare services brought into focus cultural differences, and explained why Eurocentric, mainstream, 'one size fits all' solutions do not work for this cohort.

Māori and Pacific worldviews are holistic, and this was evident in the responses to the interviews. The participants' perceptions and ways of seeing their world are all-encompassing. The use of methodological triangulation presented a platform to capture these perspectives. It also provided an approach that embodies the values and beliefs entrenched within Māori and Pacific ways of thinking and doing. Thus, kaupapa Māori research, fa'a Samoa methods, and qualitative research methods proved to be practical tools to gain insights into the perspectives of Māori and Pasifika elders, within a broader context.

The literature review provided a context for the study and supported the contention that Māori and Pacific health programmes needs to be culturally appropriate. Without this, under-representation of kaumātua Māori and Pasifika elders engaging in mainstream healthcare interventions will remain the status quo. The importance of culture and family, the impact of colonisation, and the Western-centric approach to wellness need to be taken into consideration if health interventions are to be effective. Te Whare Tapa Whā and Poutu frameworks drawn from kaupapa Māori theory, and fa'a Samoa, facilitated a holistic agenda. It captured the perspectives of kaumātua Māori and Pacific elders and their interpretation of wellness through their personal experiences.

The benefits for my relationship with the participants were reciprocal, in the sense that they were prompted to consider their wellness as critical to their families. Throughout, the importance of family was palpable. As a *mokopuna* (grandchild), the benefits I accrued went well beyond the academic rewards. This *whakatauki* (proverb) captures their attitudes towards me and their generosity in sharing their views:

He taonga te mokopuna, kia whāngaia, kia tipu, kia rea
A child is a treasure, to be nurtured, to grow, to flourish

This experience validated my feelings towards older people and my commitment to advancing their health and wellbeing. I felt privileged to spend quality time with them, strengthening my deep love and respect that I felt was mutual. Throughout the interviews, the impact of poverty on their health and wellbeing was poignantly obvious. It also highlights the enormity of the challenges required to address the health disparities of Māori and Pacific people.

As already mentioned, the literature identifies the barriers to mainstream healthcare interventions, of which poverty is a devastating threat. It also indicates that Māori and Pacific wellness strategies need to be multi-faceted and include wrap-around services. However, improving the experiences of kaumātua Māori and Pasifika elders within healthcare services is a critical first step. Access to services such as government and community financial assistance and services is an intervention that will positively impact the wellbeing of the elderly and their whānau.

The findings from the research strongly indicate that health interventions with a Western-centric design are not the most effective strategy to address health inequities in Māori and Pacific older adults. It also affirms that ethnic divergence affects perspectives of wellness. While there were already established cultural restraints that influence participation in healthcare services, the research findings provided information on the shared cultural determinants that inform wellness for kaumātua Māori and Pasifika elders. Connecting and establishing meaningful relationships between healthcare providers and Māori and Pasifika elders is key to positive and meaningful engagement.

This research contributes to the field of Māori and Pasifika health by bringing forward the key indicators that inform kaumātua Māori and Pasifika elders' engagement in healthcare services.

Because there is a lack of research surrounding health and Māori and Pacific older adults, I have referenced Māori and Pacific research related to health within a general context, to seek and establish an understanding of specific cultural determinants. This research is empowering for healthcare service providers and Māori and Pacific populations. It also validates both Māori and Pacific knowledge and challenges the paradigms that continue to fail Polynesian people.

Whanaungatanga and social togetherness were prominent aspects of this study and presented according to the findings of Warbrick et al. (2016); healthcare interventions should include the relevant factors to enhance programme development. Because Māori and Pasifika elders have a collective approach to most activities, healthcare services and interventions should operate similarly, to adhere to cultural norms. Additionally, the importance of family was central throughout the literature and interviews, and this sheds light on the potentiality of whānau-based

approaches for elders. In particular, instead of focusing on the development of interventions for older people, designing interventions that target families may prove to be more efficacious. In this way, the health of elderly participants can be indirectly affected through collective engagement in healthcare interventions.

Although a person determines the status quo for engagement within healthcare services, it is ultimately up to healthcare services to ensure that these interventions are known and accessible. Despite the availability of resources to assist in wellness, they are still unknown for the most part. A common finding of the study was that elders were not aware of the relevant services designed to optimise health for older people.

Ethnic-specific Determinants and Potential Applications

Although there are similarities between Māori and Pasifika knowledge, the individual aspects relevant to ethnicity uniquely define them. Similarly, in this research, although there were common themes throughout the findings, there were also ethnic-specific determinants that are notable.

For Māori, the value of the land and the natural world was expressed consistently throughout the literature and the interviews. Papatūānuku is the land, the earth mother that provides a place of unity and sustenance. This inquiry emphasises the importance of the natural world and draws attention to the impact it has on kaumātua Māori. For most, time at *hau kainga* (ancestral lands) was a time of serenity and revitalisation. It allowed for a time to recognise cultural identity through whakapapa and the practice of *whakawhanaungatanga* (building relationships). These lessons are essential because they identify potential intervention locations, particularly marae-based health interventions.

For Pasifika, the interviews indicated religious centrality as an integral part of Pasifika culture. Thus, throughout the entirety of this inquiry, the participants knowledge of church and prayer was present. This knowledge brings to the forefront the potentiality of church-related health interventions as a means to wellness.

Among Pacific cultures, social hierarchy reflects the historical, social structure of Pacific society. The title of an individual can indicate a person's social status and social importance within the community. For example, figures in roles such as Church Ministers are perceived as having a high social standing and thus have an important social presence within Pacific communities; they have a strong ability to influence Pasifika people. Understanding the value

of a person's title for the Pacific people identifies the essential personalities that can help inform their respective communities.

In light of COVID-19 and the implications, it had with nationwide lockdowns and social isolation, the findings further affirm the significance of the relevant cultural values for Māori and Pasifika people. For most, isolation from the wider family was troublesome; however, the time in lockdown was enjoyed and meaningful for those elders who lived amongst their immediate family. Additionally, those elders with jobs brought attention to the wage subsidy scheme implemented by New Zealand Government. The time off at home while receiving financial support was seen as a privilege. The main takeaway from the data surrounding the response to COVID-19 and Māori and Pasifika elders was the importance of prayer. Invoking spiritual guidance is a common practice central to Māori and Pasifika communities. The use of prayer was highly prevalent during the COVID-19 pandemic.

Future Research

From the interviews, it was apparent that participants' experiences in the past with healthcare services informed their future engagement. For some, a negative experience in the past deterred them from seeking any form of healthcare service, unless it was a last resort. Most of the negative experiences from this research stemmed from a lack of cultural competency in the services provided by health professionals. Therefore, the lower participation rates of older Māori and Pasifika may occur because they are not arriving at a point where they can be informed, which draws attention to the quality of care from health professionals during the consultation phase.

It is known that health professionals who are more culturally aware and culturally sensitive to the needs of their patients are more inclined to have more meaningful interactions, which in turn, can influence health outcomes. In the future, looking into data surrounding the quality of care delivered by health professionals might prove beneficial to understand if the standard of healthcare services is where it needs to be.

References

Allen, J., Alpass, F. M., & Stephens, C. V. (2019). New Zealand health, work, and retirement longitudinal study. In D. Gu & M. E. Dupre (Eds.), *Encyclopedia of Gerontology and Population Aging*. Springer. https://doi.org/10.1007/978-3-319-69892-2_977-2

Avendano, M., Glymour, M., Banks, J., & Mackenbach, J. (2009). Health disadvantage in US adults aged 50 to 74 years: A comparison of the health of rich and poor Americans with that of Europeans. *American Journal of Public Health*, 99(3), 540–548.

Azungah, T. (2018). Qualitative research: Deductive and inductive approaches to data analysis. Qualitative Research Journal, 18(4), 383-400. https://doi.org/10.1108/qrj-d-18-00035

Bansal, P., Smith, W. K., & Vaara, E. (2018). New ways of seeing through qualitative research. *Academy of Management Journal*, *61*(4), 1189–1195. https://doi.org.nz/10.5465/amj.2018.4004

Barlow, C. (1991). *Tikanga whakaaro: Key concepts in Māori culture.* Oxford University Press.

Barnes, H. M. (2000). *Kaupapa Māori: Explaining the ordinary.* University of Auckland.

Barnett, L., & Kendall, E. (2011). Culturally appropriate methods for enhancing the participation of Aboriginal Australians in health-promoting programs. *Health Promotion Journal of Australia*, *22*(1), 27–32. https://doi.org/10.1071/he11027

Barwick, H. (2000). *Improving access to primary care for Māori and Pacific peoples: A literature review*. Health Funding Authority

Bathgate, M., Donnell, A., & Mitikulena A. (1994). *The health of Pacific Islands people in New Zealand* (Analysis and Monitoring Report 2). Public Health Commission.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *Qualitative Report*, *13*(4), 544–559.

Bishop, R. (1996). *Collaborative research stories: Whakawhanaungatanga*. Dunmore Press.

Bishop, R. (1998). Freeing ourselves from neo-colonial domination in research: A Maori approach to creating knowledge. *International Journal of Qualitative Studies in Education*, *11*(2), 199–219. https://doi.org/10.1080/095183998236674

Blakely, T., Tobias, M., Atkinson, J., Yeh, L-C., & Huang K. (2007). Tracking disparity: Trends in ethnic and socioeconomic inequalities in mortality, 1981–2004. Ministry of Health.

Booth, F. W., Roberts, C. K., & Laye, M. J. (2012). Lack of exercise is a major cause of chronic diseases. *Comprehensive Physiology*, *2*(2), 1143–1211. https://doi.org/10.1002/cphy.c110025

Boulton, A., Gifford, H., & Tamehana, J. (2010, June 6–9). Resilience and whānau ora: Seeking understanding *beyond* our first impression [Paper presentation]. 4th International Traditional Knowledge Conference, Auckland, New Zealand.

http://www.maramatanga.ac.nz/sites/default/files/NPM2010TraditionalKnowledgeConferenceProceedings.pdf

Boulton, A., Tamehana, J., & Brannelly, P. (2013). Whānau-centred health and social service delivery in NZ: The challenges to, and opportunities for, innovation. *MAI Journal: A New Zealand Journal of Indigenous Scholarship*, 2(1), 18–32.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Buck, P. (1954). *Vikings of the sunrise*. Whitcombe & Tombs.

Butcher, E., & Breheny, M. (2016). Dependence on place: A source of autonomy in later life for older Māori. *Journal of Aging Studies*, 37, 48–58. https://doi.org/10.1016/j.jaging.2016.02.004

Came, H. A., McCreanor, T., Doole, C., & Simpson, T. (2016). Realising the rhetoric: Refreshing public health providers' efforts to honour te Tiriti o Waitangi in New Zealand. *Ethnicity & Health*, *22*(2), 105–118. https://doi.org/10.1080/13557858.2016.1196651

Came, H., McCreanor, T., Haenga-Collins, M., & Cornes, R. (2019). Maori and Pasifika leaders' experiences of government health advisory groups in New Zealand. *Kōtuitui: New Zealand Journal of Social Sciences Online*, *14*(1), 126–135. https://doi.org/10.1080/1177083x.2018.1561477

Chant, L. (2011). Whānau Ora: Hauora Māori models for kotahitanga/cooperative coexistence with *non*-Māori. *AlterNative*, 7(2), 111–122. https://doi.org/10.1177/117718011100700204

Christensen, K., Doblhammer, G., Rau, R., & Vaupel, J. W. (2009). Ageing populations: The challenges ahead. *The Lancet*, 374(9696), 1196–1208.

Cowley, E., Paterson, J., & Williams, M. (2004). Traditional gift giving among Pacific families in New Zealand. *Journal of Family and Economic Issues*, *25*(3), 431–444. https://doi.org/10.1023/b:jeei.0000039949.35285.20

Cram, F. (2006). Talking ourselves up. *AlterNative: An International Journal of Indigenous Peoples*, *2*(1), 28–43. https://doi.org/10.1177/117718010600200102

Cram, F. (2017). Kaupapa Māori health research. *Handbook of Research Methods in Health Social Sciences*, 1–18. https://doi.org/10.1007/978-981-10-2779-6_30-1

Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2nd ed.). Sage.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Sage.

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. BMC Medical Research Methodology, 11, 100. https://doi.org/10.1186/1471-2288-11-100

Curtis, E. (2016). Indigenous positioning in health research: The importance of Kaupapa Māori theory-informed practice. *AlterNative: An International Journal of Indigenous Peoples*, *12*(4), 396–410. https://doi.org/10.20507/alternative.2016.12.4.5

Denzin, N. K., & Lincoln, Y. S. (2005). *The Sage handbook of qualitative research*. Sage.

Dewes, O., & McColl, A. (2015). Vaikoloa: Research with Pacific church communities; Overdone or under-committed? *Journal of Primary Health Care*, *7*(4), 349. https://doi.org/10.1071/hc15349

Dewes, O., Scragg, R., & Raina Elley, C. (2013). The association between church attendance and obesity-related lifestyle behaviours among New Zealand adolescents from different Pacific ethnic groups. *Journal of Primary Health Care*, *5*(4), 290. https://doi.org/10.1071/hc13290

Durie, M. (1994). *Whaiora: Maori health development*. Oxford University Press.

Dyall, L., Kepa, M., Teh, R., Mules, R., Moyes, S. A., Wham, C., Hayman, K., Connolly, M., Wilkinson, T., Keeling, S., Loughlin, G., Jatrana, S., & Kerse, N. (2014). Cultural and social factors and quality of life of Maori in advanced age: Te puawaitanga o nga tapuwae kia ora tonu–Life and living in advanced age; A cohort study in New Zealand (LiLACS NZ). *The New Zealand Medical Journal,* 127(1393), 62–79.

Dyck, I., & Kearns, R. (1995). Transforming the relations of research: Towards culturally safe geographies of health and healing. *Health & Place*, *1*(3), 137–147. https://doi.org/10.1016/1353-8292(95)00020-m

Elley, C. R., Kerse, N., Arroll, B., & Robinson, E. (2003). Effectiveness of counselling patients on physical activity in general practice: Cluster randomised controlled trial. *BMJ*, *326*(7393), 793–793. https://doi.org/10.1136/bmj.326.7393.793

Ellison-Loschmann, L., & Pearce, N. (2006). Improving access to health care among New Zealand's Maori population. *American Journal of Public Health*, *96*(4), 612–617. https://doi-org.ezproxy.aut.ac.nz/10.2105/AJPH.2005.070680

Esera, F. I. (2001). If a client is operating from a Samoan world view how can s/he be holistically and appropriately treated under the Western medical model? [Master's thesis, Victoria University of Wellington]. ResearchArchive. http://hdl.handle.net/10063/104

Foliaki L. (2002). Waitemata District Health Board: Draft cultural competency standards for Pacific mental health workers [Paper presentation]. Sixth Conference of the Health Promotion Forum of New Zealand, Christchurch, New Zealand.

Fusch, P., Fusch, G. E., & Ness, L. R. (2018). Denzin's paradigm shift: Revisiting triangulation in qualitative research. *Journal of Social Change*, 10(1), 19–32. ttps://doi.org/10.5590/JOSC.2018.10.1.02

Gifford, H., Cvitanovic, L., Boulton, A., & Batten, L. (2017). Constructing prevention programmes with a Māori health service provider view. *Kōtuitui: New Zealand Journal of Social Sciences Online*, *12*(2), 165–178. https://doi.org/10.1080/1177083x.2017.1352521

Goins, R. T., Garroutte, E. M., Fox, S. L., Dee Geiger, S., & Manson, S. M. (2011). Theory and practice in participatory research: Lessons from the Native Elder Care Study. *The Gerontologist*, 51, 285–294. https://doi.org/10.1093/geront/gnq130

Google. (n.d.-a). [Samoa, Sa'anapu]. Retrieved July 12, 2021, from https://goo.gl/maps/JbgqdZ6YgEpBPpMp8

Google. (n.d.-b). [*Waiti Marae].* Retrieved July 12, 2021, from https://goo.gl/maps/BbXL28uccddE12m8A

Gordon, B., Sauni, P., & Tuagalu, C. (2013). Sport means 'family and church': Sport in New Zealand Pasifika communities. *Asia-Pacific Journal of Health, Sport and Physical Education*, *4*(1), 49–63. https://doi.org/10.1080/18377122.2013.760427

Graham, J. (2009). Nā Rangi tāua, nā Tūānuku e takoto nei: Research methodology framed by whakapapa. *Mai Review.* 1, 1–9.

Griffin-Pierce, T., Silverberg, N., Connor, D., Jim, M., Peters, J., Kaszniak, A., & Sabbagh, M. N. (2008). Challenges to the recognition and assessment of Alzheimer's disease in American Indians of the southwestern United States*. Alzheimer's & Dementia: the Journal of the Alzheimer's Association, 4*(4), 291–299. https://doi.org/10.1016/j.jalz.2007.10.012

Guiney, H., Keall, M., & Machado, L. (2018). Physical activity prevalence and correlates among New Zealand older adults. *Journal of Aging and Physical Activity*, *26*(1), 75–83. https://doi.org/10.1123/japa.2016-0393

Hamlin, M., Yule, E., Elliot, C., Stoner, L., & Kathiravel, Y. (2016). Long-term effectiveness of the New Zealand Green Prescription primary health care exercise initiative. *Public Health*, 140, 102-108. http://doi.org/10.1016/j.puhe.2016.07.014

Harmsworth, G., & Awatere, S. (2012). Māori values – Iwi/hapū perspectives of freshwater management in the Auckland region. (*LCR Report LC939 for the Auckland Council).* Manaaki Whenua Landcare Research.

Harrison, H., Birks, M., Franklin, R., & Mills, J. (2017). Case study research: Foundations and methodological orientations. *Forum*: *Qualitative Social Research*, *18*(1). https://doi.org/10.17169/fqs-18.1.2655

Hately, G., & Mandic, S. (2019). Physical activity, physical function and quality of life in community-based maintenance cardiac rehabilitation. *Health Education Journal*, *78*(5), 524–536. https://doi.org/10.1177/0017896918823821

Hau‘ofa, E. (1985). The future of our past. In R. C. Kiste, &r. A. Herr (Eds.) *In The Pacific Islands in the year 2000* (pp. 151–169). Working Paper series. Center for Asian and Pacific Studies, University of Hawaii at Manoa.

Hiha, A. A. (2015). Kaupapa Māori methodology: Trusting the methodology through thick and thin. *The Australian Journal of Indigenous Education*, *45*(2), 129–138. https://doi.org/10.1017/jie.2015.30

Hobbs, M., Ahuriri-Driscoll, A., Marek, L., Campbell, M., Tomintz, M., & Kingham, S. (2019). Reducing health inequity for Maori people in New Zealand. *The Lancet*, *394* (10209), 1613–1614. https://doi.org/10.1016/s0140-6736(19)30044-3

Holkup, P. A., Salois, E. M., Tripp-Reimer, T., & Weinert, C. (2007). Drawing on wisdom from the past: An elder abuse intervention with tribal communities. *The Gerontologist*, 47, 248–254. https://doi.org/10.1093/%20geront/47.2.248

Holt, K. L., & Karalus, E. (2017). K'aute Pasifika workplace health and well-being programme. *International Journal of Integrated Care*, *17*(3), 105. https://doi.org/10.5334/ijic.3217

Irwin K. (1994). Māori research methods and processes: An exploration. *Sites*, 28, 25–43.

Jackson, A. (2015). Kaupapa Māori theory and critical Discourse Analysis: Transformation and social change. *AlterNative: An International Journal of Indigenous Peoples*, *11*(3), 256–268. https://doi.org/10.1177/117718011501100304

Jackson, A. (2015). Kaupapa Māori theory and critical Discourse Analysis: Transformation and social change. *AlterNative: An International Journal of Indigenous Peoples*, *11*(3), 256-268. https://doi.org/10.1177/117718011501100304

Johnson, R. B., & Christensen, L. (2012). *Educational research: Quantitative, qualitative, and mixed approaches* (4th ed.). Sage.

Ka'ai, T.M., & Higgins, R. (2004). Te ao Māori: A Māori world-view. In T. M. Ka'ai, J. C. Moorfield, M. P. J. Reilly, & S. Mosley (Eds.), *Ki te whaiao. An introduction to Māori culture and society*. (pp. 13–25). Pearson Education.

Kawharu, M. (2000) Kaitiakitanga: A Māori anthropological perspective of the Māori socio-environmental ethic of resource management. *Journal of the Polynesian Society,* 109, 349–370.

Keogh, J., Rice, J., Taylor, D., & Kilding, A. (2014). Objective benefits, participant perceptions and retention rates of a New Zealand community-based, older-adult exercise programme. *Journal of Primary Health Care*, *6*(2), 114. https://doi.org/10.1071/hc14114

Kerse, N., Elley, C. R., Robinson, E., & Arroll, B. (2005). Is physical activity counseling effective for older people? A cluster randomized, controlled trial in primary care. Journal of the American Geriatrics Society, 53(11), 1951–1956. https://doi.org/10.1111/j.1532-5415.2005.00466.x

King, A. (2000). *The New Zealand health strategy*. Ministry of Health.

Kirk, J., & Miller, M. L. (1986). *Reliability and validity in qualitative research*. Sage.

Kolt, G. S., Paterson, J. E., & Cheung, V. Y. (2006). Barriers to physical activity participation in older Tongan adults living in New Zealand. *Australasian Journal on Ageing*, *25*(3), 119–125. https://doi.org/10.1111/j.1741-6612.2006.00157.x

Lavoie, J. G., Forget, E. L., Prakash, T., Dahl, M., Martens, P., & O'Neil, J. D. (2010). Have investments in on-reserve health services and initiatives promoting community control improved First Nations' health in Manitoba? *Social Science & Medicine*, *71*(4), 717–724. https://doi.org/10.1016/j.socscimed.2010.04.037

Lee, I., Shiroma, E. J., Lobelo, F., Puska, P., Blair, S. N., & Katzmarzyk, P. T. (2012). Effect of physical inactivity on major non-communicable diseases worldwide: An analysis of burden of disease and life expectancy. *The Lancet*, *380*(9838), 219–229. https://doi.org/10.1016/s0140-6736(12)61031-9

Lesuma, C. (2019). Sa Nafanuā: Reconstituting Nafanua as female empowerment in Samoan diasporic literature. *The Journal of American Folklore*, *132*(525), 260. https://doi.org/10.5406/jamerfolk.132.525.0260

Liki Chan Tung, A. (2015). *Women as kin: Working lives, living work and mobility among Samoan Teine uli'.* In J.A. Bennett (Ed.), Oceanian journeys and sojourns: Home thoughts abroad. (pp. 126–159). Otago University Press.

Loprinzi, P. D., & Frith, E. (2018). Association between perceived physical activity and cognitive function in older adults. *Psychological Reports*, *122*(1), 108–116. https://doi.org/10.1177/0033294117750632

Low, P. K. (2014). Are you thinking like an Islander? Or more so like a cosmopolitan? *International Journal of Business and Social Science*, *5*(9), 59–66. https://ijbssnet.com/journals/Vol_5_No_9_August_2014/7.pdf

Mackay, L., Egli, V., Booker, L., & Prendergast, K. (2019). New Zealand's engagement with the five ways to wellbeing: Evidence from a large cross-sectional survey. *Kōtuitui: New Zealand Journal of Social Sciences Online*, *14*(2), 230–244. https://doi.org/10.1080/1177083x.2019.1603165

Mahuika, A. (1998). Whakapapa is the heart. In K. S. Coates & P. G. McHugh (Eds.), *Living relationships: Kokiri Ngatahi: The Treaty of* Waitangi *in the new millennium.* (pp. 215–221). Victoria University Press.

Mahuika, N. (2011). 'Closing the gaps': From postcolonialism to Kaupapa Māori and beyond. *New Zealand Journal of History*, 45(1), 15–32.

Maldonado-Torres, N. (2011). Thinking through the decolonial turn: Post-continental interventions in theory, philosophy, and critique—An introduction*. Transmodernity: Journal of Peripheral Cultural Production of the Luso-Hispanic World*, 1, 1–15.

Mark, G. T., & Lyons, A. C. (2010). Maori healers' views on wellbeing: The importance of mind, body, spirit, family and land. *Social Science & Medicine*, *70*(11), 1756–1764. https://doi.org/10.1016/j.socscimed.2010.02.001

Marsden, M. (1992). God, man and the universe: A Māori view. In M. King (Ed.), *Te ao hurihuri: The world moves on*. Hicks Smith & Sons.

Marsden, M. (2003). *The woven universe: Selected writings of Rev. Māori Marsden* (T. A. C. Royal, Ed.) Estate of Rev Māori Marsden.

McGloin, S. (2008). The trustworthiness of case study methodology. Nurse Researcher, 16(1), 45–55. https://doi.org/10.7748/nr2008.10.16.1.45.c6752

McLaughlin, L. A., & Braun, K. L. (1998). Asian and Pacific Islander cultural values: Considerations for health care decision making. *Health & Social Work*, *23*(2), 116–126. https://doi.org/10.1093/hsw/23.2.116

McMurray, A., & Param, R. (2008). Culture-specific care for Indigenous people: A primary health care perspective. *Contemporary Nurse*, *28*(1-2), 165–172. https://doi.org/10.5172/conu.673.28.1-2.165

Mead, H. M. (2003). *Tikanga Māori: Living by Māori values*. Huia Publishers.

Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research: A guide to design and implementation* (4th ed.). Jossey-Bass.

Metge, J. (1995). *New growth from old: The whanau in the modern world*. Victoria University Press.

Mills, A. J., Durepos, G., & Wiebe, E. (2010). *Encyclopedia of case study research*. Sage Publications. https://doi.org/10.4135/9781412957397

Ministry of Health. (2009). *Report on New Zealand cost-of-illness studies on long-term conditions.* https://www.health.govt.nz/publication/report-new-zealand-cost-illness-studies-long-term-conditions

Ministry of Health. (2016). *Annual update of key results 2015/16: New Zealand Health Survey*. https://www.health.govt.nz/system/files/documents/publications/annual-update-key-results-2015-16-nzhs-dec16-v2.pdf

Ministry of Health. (2019). *Historical mortality* [Data set]. https://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/mortality-data-and-stats

Murton, B. (2012). Being in the place world: Toward a Māori "geographical self." *Journal of Cultural Geography*, *29*(1), 87–104. https://doi.org/10.1080/08873631.2012.655032

Myers, J., Kaykha, A., George, S., Abella, J., Zaheer, N., Lear, S., Yamazaki, T., & Froelicher, V. (2004). Fitness versus physical activity patterns in predicting mortality in men. *The American Journal of Medicine*, *117*(12), 912–918. https://doi.org/10.1016/j.amjmed.2004.06.047

New Zealand Treasury. (2017). District Health Board financial performance to 2016 and 2017 plans. https://treasury.govt.nz/sites/default/files/2017-05/dhb-performance-feb17.pdf

Oetzel, J. G., Hokowhitu, B., Simpson, M., Reddy, R., Cameron, M. P., Meha, P., Johnston, K., Nock, S., Greensill, H., Harding, T., Shelford, P., & Smith, L. T. (2019a). Correlates of health-related quality of life for Maori elders involved in a peer education intervention. *Journal of Health Communication*, *24*(5), 559–569. https://doi.org/10.1080/10810730.2019.1637483

Oetzel, J. G., Hokowhitu, B., Simpson, M., Reddy, R., Nock, S., Greensill, H., Cameron, M. P., Meha, P., Johnston, K., Harding, T., Shelford, P., & Smith, L. T. (2019b). Kaumātua mana motuhake: A study protocol for a peer education intervention to help Maori elders work through later-stage life transitions. *BMC Geriatrics*, *19*(1). https://doi.org/10.1186/s12877-019-1041-2

Owen, N., Sparling, P. B., Healy, G. N., Dunstan, D. W., & Matthews, C. E. (2010). Sedentary behavior: Emerging evidence for a new health risk. *Mayo Clinic Proceedings*, *85*(12), 1138–1141. https://doi.org/10.4065/mcp.2010.0444

Pasefika Proud. (2016). *The profile of Pacific peoples in New Zealand.* https://www.pasefikaproud.co.nz/assets/Resources-for-download/PasefikaProudResource-Pacific-peoples-paper.pdf

Pasikale, A., George, T., Intra Family Income Project., & Destini Inc. (1995). *For the family first: A study of income allocation within Pacific Islands families in New Zealand; The Pacific Islands component of the Intra Family Income & Resource Allocation Project.* Wellington, N.Z: Destini Inc.

Peace, S., Kellaher, L., & Holland, C. (2005). *Environment and identity in later life*. McGraw-Hill Education (UK).

Penney, L., Barnes, H. M., & Mccreanor, T. (2011). The blame game: Constructions of Māori medical compliance. *AlterNative: An International Journal of* Indigenous *Peoples*, *7*(2), 73–86. https://doi.org/10.1177/117718011100700201

Pihama, L. (2010). Kaupapa Māori theory: Transforming theory in Aotearoa. *He Pukenga Korereo: A Journal of Māori Studies, 9*(2), 5–14. http://www.hepukengakorero.com/index.php/HPK/article/viewFile/2/pdf

Pihama, L., Reynolds, P., Smith, C., Reid, J., Smith, L. T., & Nana, R. T. (2014). Positioning historical trauma theory within Aotearoa New Zealand. *AlterNative: An International Journal of Indigenous Peoples*, *10*(3), 248–262. https://doi.org/10.1177/117718011401000304

Podmore, V. N., Wendt Samu, T., & A'oga Fa'a Samoa. (2006). O le tama ma lana a'oga, O le tama ma lona fa'asinomaga: Nurturing positive identity in children: Final research report from the A'oga Fa'a Samoa, an Early Childhood Centre of Innovation. Ministry of Education. http://www.educationcounts.govt.nz/publications/ece/22551/22555

Prior, I., Rose, B., Harvey, H., & Davidson, F. (1966). Hyperuricaemia, gout, and diabetic abnormality in Polynesian people. *The Lancet*, *287*(7433), 333-338. https://doi.org/10.1016/s0140-6736(66)91320-1

Pulotu-Endemann, F. K. (2001). Fonofale Model of Health. https://whanauoraresearch.co.nz/wp-content/uploads/formidable/Fonofalemodelexplanation1-Copy.pdf

Rameka L. (2016). Whakapapa: A Māori way of knowing and being in the world. In M. Peters (Ed.), *Encyclopedia of Educational Philosophy and Theory.* Springer. https://doi.org/10.1007/978-981-287-532-7_172-1

Reid, J., Varona, G., Fisher, M., & Smith, C. (2016). Understanding Maori 'lived' culture to determine cultural connectedness and wellbeing. *Journal of Population Research*, *33*(1), 31–49. https://doi.org/10.1007/s12546-016-9165-0

Reid, P., & Robson, B. (2007). Understanding health inequities. In B. Robson & R. Harris, *Hauora, Māori standards of health: A study of the years 2000-2005* (pp. 3–10). Te Rōpū Rangahau Hauora a Eru Pōmare.

Reilly, M. P. J. (2004). Te tīmatanga mai o ngā atua: Creation narratives. In T. M. Ka'ai, J. C. Moorfield, M. P. J. Reilly & S. Mosely (Eds.) *Ki te whaiao: An introduction to Māori culture and society* (pp. 1–12). Pearson Education.

Rochford, T. (2004). Whare Tapa Whā: A Māori model of a unified theory of health. *The Journal of Primary Prevention, 25*(1), 41–57. https://doi.org/10.1023/b:jopp.0000039938.39574.9e

Rodriguez, L., George, J. R., & McDonald, B. (2017). An inconvenient truth: Why evidence-based policies on obesity are failing Maori, Pasifika and the Anglo working class. *Kōtuitui: New Zealand Journal of Social Sciences Online*, *12*(2), 192–204. https://doi.org/10.1080/1177083x.2017.1363059

Ryan D., Grey C., & Mischewski B. (2019). Tofa Saili: A review of evidence about health equity for Pacific peoples in New Zealand. Pacific Perspectives.

Sa'u Lilo, L., Tautolo, E., & Smith, M. (2020). Health literacy, culture and Pacific peoples in Aotearoa, New Zealand: A review. *Pacific Health*, *3*. https://doi.org/10.24135/pacifichealth.v3i0.4

Scharp, K. M., & Sanders, M. L. (2018). What is a theme? Teaching thematic analysis in qualitative communication research methods. *Communication Teacher, 33*(2), 117–121, https://doi.org/10.1080/17404622.2018.1536794

Schluter, P., Carter, S., & Kokaua J. (2007). Indices and perception of crowding in Pacific households domicile within Auckland, New Zealand: Findings from the Pacific Islands Families Study. *New Zealand Medical Journal*, *120*(1248).

Schmid, D, & Leitzmann, M. F. (2014). Cardiorespiratory fitness as predictor of cancer mortality: A systematic review and meta-analysis. *Annals of Oncology 26*(2), 272–278. https://doi.org/10.1093/annonc/mdu250

Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English Language Teaching*, *5*(9). https://doi.org/10.5539/elt.v5n9p9

Seiuli, B. M. S. (2012). Uputaua: A therapeutic approach to researching Samoan communities. *The Australian* Community *Psychologist,* 24(1), 24–37. https://hdl.handle.net/10289/9826

Siauane, L. L. (2004). *Fa'aSamoa: A look at the evolution of the fa'aSamoa in Christchurch* [Master's thesis, University of Canterbury]. UC Research Repository. http://hdl.handle.net/10092/899

Sims-Gould, J., Franke, T., Lusina-Furst, S., & McKay, H. A. (2019). Community health promotion programs for older adults: What helps and hinders implementation. *Health Science Reports*, *3*(1). https://doi.org/10.1002/hsr2.144

Smith, L.T. (2012). *Decolonizing methodologies: Research and Indigenous peoples* (2nd ed.). Zed Books.

Stake, R. E. (1995). *The art of case study research*. Sage.

Stypinska, J. (2009). Social construction of age and age inequalities. Conference Papers - American Sociological Association, 1.

Talemaitoga, A. (2011). Vaikoloa: Pacific peoples; Our health and wellbeing. *Journal of Primary Health Care*, *3*(2), 167. https://doi.org/10.1071/hc11167

Tamasese, T. K., Parsons, T., Sullivan, G., & Waldegrave, C. (2010). *A qualitative study into Pacific perspectives on cultural obligations and volunteering*. Pacific Section; The Family Centre Social Policy Research Unit.

Tavana, N. (2002). Traditional knowledge is the key to sustainable development in Samoa: Examples of ecological, botanical and taxonomical knowledge. Proceedings of the 2001 National Environmental Forum, 3, pp. 19–90. Ministry of Natural Resources and Environment.

Te Puni Kokiri. (2010). A framework for monitoring Maori development (Working Paper One). Ministry of Maori Development.

Thomsen, S., Tavita, J., & Levi-Teu, Z. (2018). *A Pacific perspective on the Living Standards Framework and wellbeing* [Discussion Paper]. New Zealand Treasury.

Walker, S., Eketone, A., & Gibbs, A. (2006). An exploration of kaupapa Maori research, its principles, processes and applications. *International Journal of Social Research Methodology*, *9*(4), 331–344. https://doi.org/10.1080/13645570600916049

Wankel, L. M. (1993). The importance of enjoyment to adherence and psychological benefits from physical activity. *International Journal of Sport Psychology, 24*(2), 151–169.

Warbrick, I., Wilson, D., & Boulton, A. (2016). Provider, father, and bro–Sedentary Māori men and their thoughts on physical activity. *International Journal for Equity in Health*, *15*(1). https://doi.org/10.1186/s12939-016-0313-0

Warburton, D. E. (2006). Health benefits of physical activity: The evidence. *Canadian Medical Association Journal*, *174*(6), 801-809. https://doi.org/10.1503/cmaj.051351

Wen, C. P., Wai, J. P., Tsai, M. K., Yang, Y. C., Cheng, T. Y., Lee, M., Chan, H. T., Tsao, C. K., Tsai, S. P., & Wu, X. (2011). Minimum amount of physical activity for reduced mortality and extended life expectancy: A prospective cohort study. *The Lancet*, *378*(9798), 1244–1253. https://doi.org/10.1016/s0140-6736(11)60749-6

Wirihana, R., & Smith, C. (2014). Historical trauma, healing and well-being in Māori communities. *MAI Journal*, *3*(3), 197–210. http://www.journal.mai.ac.nz/content/historical-trauma-healing-and-well-being-m%C4%81ori-communities

World Health Organization. (2020). *International classification of functioning, disability and health (ICF)*. https://www.who.int/standards/classifications/international-classification-of-health-interventions

World Health Organization. (2021). *Coronavirus disease (COVID-19)*. https://www.who.int/emergencies/diseases/novel-coronavirus-2019

Wright-St Clair, V. A., Kepa, M., Hoenle, S., Hayman, K., Keeling, S., Connolly, M., & Kerse, N. (2012). Doing what's important: Valued activities for older New Zealand Māori and non-Māori. *Australasian Journal on Ageing*, *31*(4), 241–46. https://doi.org/10.1111/j.1741-6612.2011.00583.x

Wright-St Clair, V., Rapson, A., Kepa, M., Connolly, M., Keeling, S., Rolleston, A., & Kerse, N. (2017). Ethnic and gender differences in preferred activities among Māori and non-Māori of advanced age in New Zealand. *Journal of Cross-Cultural Gerontology, 32*(4), 433–446. https://doi.org/10.1007/s10823-017-9324-6

Wright, S., & Hornblow, A. (2008). Emerging needs, evolving services: The health of Pacific peoples in New Zealand. *Kotuitui: New Zealand Journal of Social Sciences Online*, *3*(1), 21–33. https://doi.org/10.1080/1177083x.2008.9522430

Yamashita, T., Bardo, A. R., & Liu, D. (2018). Experienced subjective well-being during physically active and passive leisure time activities among adults aged 65 years and older. *The Gerontologist*, *59*(4), 718–26. https://doi.org/10.1093/geront/gny106

Zavala, M. (2013). What do we mean by decolonizing research strategies? Lessons from decolonizing, Indigenous research projects in New Zealand and Latin America, *Decolonization: Indigeneity, Education & Society*, *2*(1), 55–71.

Appendix

Letter of Support form Waiti Committee

AUT Ethics Committee (AUTEC)
Te Ara Poutama
Auckland University of Technology

To whom it may concern,

We are writing on behalf of Waiti Raungaunu Marae in support of Denzel Laumatia-Paki's proposal to research within the marae and amongst the iwi. We strongly support the kaupapa and the focus on reducing health disparities among kaumātua in Aotearoa.

We look forward to working with you.

Sincerely,

Puke (Chairperson)

Waiti Raungaunu Marae Board
Waiti Road, Tahuna 3373