

Māori realities, intimacies, and sexual expressions: reconceptualising consent to uphold kaumātua mana in aged residential care

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Abstract

Increasingly, kaumātua (Māori elders) in Aotearoa (New Zealand) live apart from whānau (Māori extended family) in residential care, where policies are shaped by post-colonial legislation and ethical principles that privilege individual rights over Indigenous priorities and rights. The communal context of residential care has created late-life opportunity for intimacy and sexual expression with new partners. These issues are addressed in the international literature, highlighting the benefits and complexities. Literature report there may be clashes between resident and family members' wishes, and tensions around privacy and consent. This article considers survey data and semi-structured interviews with kaimahi (Māori care workers) and a kaumātua who were part of a larger study of staff, residents, and family in the residential aged care context. Post-colonial individualistic rights-based approaches do not necessarily fit with a Māori worldview. A Māori-led articulation of consent is essential to uphold the mana (authority, influence, power) of kaumātua and whānau.

Keywords

dementia, Indigenous ethics, intimacy, Māori, sexuality, whānau

Introduction

Caring for kaumātua (Māori elders) in any care context means to value their worldviews and those of their whānau (extended family). This recognition is especially true when it comes to the ethics of consent. This article addresses the ethics of consent around intimacy and sexual expression for kaumātua in residential care. Contemporary notions of consent in care contexts are largely shaped by western legal traditions (Schouten et al., 2021), and whether such notions are appropriate are the focus of this article. For the purposes of this article, intimacy means any emotional and physical closeness, or touch provided by someone other than a caregiver providing necessary care. The data for this article are drawn from a national 3-year research study undertaken in Aotearoa (New Zealand) (Henrickson et al., 2020). While Māori were not the exclusive focus of the national study, we were so impressed by Māori participants telling that we felt it was important to honour kaumātua and make their voices heard beyond the usual technical research reports and contexts.

Although there is a significant international literature that addresses the intersections of intimacy, sexuality, and consent in the residential care context, none of that literature is situated in Indigenous constructions of consent. In the

nursing and social care practice literature, there is significant focus on cultural and epistemological competence especially when practitioners are working in specific cultural contexts (Hardy, 2018; MacFarlane, 2012; Warbrick et al., 2016). Working from an epistemologically competent perspective means not merely understanding cultural differences, or even the meanings conveyed by those differences, but being able to view the world from the care recipient's perspective, a kind of radical empathy; this is inevitably an iterative, hermeneutic process (Henrickson, 2005). Our context is further informed by Te Tiriti o Waitangi (The Treaty of Waitangi), signed between many Māori iwi (tribes) and the British colonial authority in 1840, which set out the responsibilities and rights of both

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Māori and British settlers, and which forms part of the constitutional arrangements of Aotearoa (Orange, 2015). We acknowledge that understanding the implications of Te Tiriti o Waitangi has been the subject of much controversy and debate (Hayward & Wheen, 2016; O'Sullivan et al., 2021; Theunissen, 2011) which lie beyond the scope of this article.

Background

All caregivers, inclusive of health professionals in this context, who work with kaumātua must deliberate about whether a kaumātua expects the inclusion of their whānau in all significant decisions or whether they are caring for a kaumātua who prefers to make their decisions independent of whānau. This responsibility is more significant for kaimahi (Māori care workers) if they are available. Such deliberation can be complex. Kaimahi need to be wide-ranging and comprehensive in their decision-making because kaumātua are a diverse group. Some kaumātua embody a traditional understanding of te ao Māori (the Māori world), one that includes interrelatedness and interconnection, while others live with a more contemporary Māori worldview of self and others, shaped by the impact of colonisation (Muru-Lanning et al., 2021; Wilson et al., 2021). Traditional te ao Māori is whānau-inclusive; increasingly, contemporary worldviews come with a more individualised sense of self. Kaimahi may be operating with different expectations and worldviews from kaumātua, having learned to navigate the ubiquity of colonialism differently, which further complicates the intersecting diversities of Māori worldviews. Only tentative assumptions can be made about how Māori across different generations or roles will make decisions.

At the project outset, guided by the first author and the kaumātua of our community advisory board, the researchers were cognisant of these differing worldviews and the legacy of colonialism. Our study was informed by mātauranga Māori (Māori knowledge). We sought to understand the distinctive contribution that Indigenous knowledge can make to our understandings of consent, sexuality, and intimacy for older persons. From the beginning of the project, we noted tensions among different definitions of consent, with legal, ethical, and regulatory constructs that understand consent as individualised, and the Māori position of collective consent (West-McGruer, 2020) and strove to identify and accommodate those tensions in our research question and methodology. The research question guiding the larger project was as follows: What kinds of ethical decisions are being made about expressions of intimacy and sexuality in aged residential care? The study arose from clinical and legal practitioners' requests for guidance about the ethical consent complexities that occur frequently in residential care.

Māori make up 16% of the total population of roughly 5 million in Aotearoa; 7.6% of people aged 65 years and older identify as Māori (Hikaka & Kerse, 2021). At this writing, more than 31,000 older adults live in residential care, of whom only 4.7% identify as Māori (InterRAI New

Zealand, 2018); this means that proportionately Māori are moving into residential care less often than tauwiwi (non-Māori people). Māori make up 10% of staff in caregiving and managerial positions in residential care (GrantThornton, 2010). Care quality is prescribed through Ministry of Health Standards, against which each facility is audited (Ministry of Health, 2022). There are specific standards that relate to Māori. However, the context of residential care is largely oriented to older adults who identify as Pākehā (a New Zealander of European descent) or other tauwiwi. Māori cultural norms are largely absent in residential care settings, although there are exemplars of successful Māori-led models (Hikaka & Kerse, 2021). It is widely documented that Māori experience differential access to appropriate, accessible, and timely health care across all sectors (Dyall et al., 2014; Selak et al., 2020); a significant contributing factor to that difference is unconscious bias in care provision (Barton, 2018). In the residential care context, Māori are disadvantaged by caregivers not fully aware of their responsibilities under Te Tiriti o Waitangi, and staff are inadequately prepared and resourced to provide mana (authority, influence, dignity) enhancing care for Māori (Hikaka & Kerse, 2021).

There are differences between the way contemporary kaumātua and tauwiwi older adults are positioned and treated in their communities. In te ao Māori, kaumātua are a taonga (treasure). Traditionally, they protect tikanga Māori (customary system of Māori values and practices) (tikanga) with a fundamental role in leadership and guidance at all levels of Māori society (Mead, 2020). The mana of kaumātua increases with age (Muru-Lanning et al., 2021), while often the dignity of tauwiwi diminishes due to the pervasive impact of ageism (Amundsen, 2022). Challenging ageism and understanding these different cultural perceptions associated with being an older adult are important in residential care, yet tauwiwi care staff may neither recognise their own culturally embedded ageism nor appreciate the cultural standing of kaumātua. For example, frailty does not remove the status of Māori elders, who are metaphorically tribal pillars (Durie, 2003; Pere, 1991; Rua et al., 2017).

Many kaumātua may not have experienced the rites of passage that give them te reo Māori (Māori language) (te reo) and tikanga to support their identity in a traditional sense (Durie, 1999). However, these in-between elders are often caught between the worlds of Māori and Pākehā and may carry a more contemporary kaumātua status. For example, their values may be traditionally Māori, while their daily life is Pākehā-oriented. Therefore, care provision must navigate two worlds; it must be mana-enhancing and focus on what is important with each kaumātua while at the same time not making assumptions about the experiences and worldviews of the kaumātua. However, all kaumātua need to be able to trust that the person who is caring for them will uphold their mana. Traditionally as kaumātua became less able to manage independently, the responsibility for maintaining mana shifted to whānau. In the contemporary context where care may be institutional, kaimahi need to recognise that care for kaumātua and their whānau must

maintain their mana motuhake (self-determination and sovereignty) (Moeke-Maxwell, 2016). The inherent worth of understanding the importance of maintaining mana cannot be underestimated, particularly in a care context that is of an individualistic post-colonial origin (Simpson et al., 2020).

Literature review

There is a dearth of literature about implications for whānau involvement in kaumātua care around consent apart from nascent research in advance care planning (Frey et al., 2014). However, in te ao Māori, collective decision-making and the responsibility to uphold the mana of kaumātua are likely to carry far more weight for whānau than the legal position of individual autonomy. The mana of a group is enhanced by the contributions of each to the whole, and the mana of the whole reflexively enhances the well-being of each person (Mead, 2020). This orientation matters a great deal in residential care when traditional whānau expect to be involved in decisions about sexuality and consent for their kaumātua, and the facility staff, working from a more legalistic or regulatory framework, expect the resident to be the consenting person. Park and Astell (2017) note the low number of older Māori who have appointed an Enduring Power of Attorney (EPA). This legal expectation in Aotearoa to appoint a single person to oversee health decisions in the event of cognitive impairment, or in the absence of this appointment to defer to a Court decision, does not fit with cultural expectations of whānau interdependence and consensus decision-making. Notions of freedom and autonomy for older Māori focus on being able to live in accordance with Māori values, rather than individualistic rights-based assumptions (Butcher & Breheny, 2016).

For tauīwi, post-Enlightenment notions of individual rights are steeped in centuries of intertwined philosophical and religious ideas which have been transferred into the colonial agenda. During the European Reformation and subsequently the Enlightenment, as the role of the priest as intermediary between the divine and the person declined, the individual became increasingly responsible for their own salvation. Eventually, the individual person became solely responsible for their relationship with the divine and with the world. Capitalism became the dominant economic philosophy, and these philosophical and economic worldviews were transported around the world during the so-called Age of Exploration. This European perspective with its understanding of individual wealth as a signal of divine favour was exported and imposed by European merchants and explorers as they occupied and colonised territory throughout the world (Henrickson, 2022). Aotearoa was not exempt from this philosophical hegemony, which was completely at odds with the Indigenous collective worldview of Māori. Colonial law in Aotearoa that was established after the 1840 Te Tiriti o Waitangi by British colonisers was premised on individual rights and responsibilities. Among other things, this means that the law did not recognise the

rights and roles of the whānau in decision-making. To this day, the whānau remain unrecognised and excluded in the consent process when a kaumātua is cognitively impaired; only a single designated individual who holds an EPA has legal authority.

The legal demarcation that gives family members the right to intervene in the welfare decisions of older persons with increasing cognitive impairment is unlikely to hold substantive meaning for Māori. Mate wareware (dementia) is understood by Māori as behavioural change that is part of normal ageing rather than a pathological condition. Although it is common for tauīwi to experience physical and social displacement with advancing dementia (Brannelly, 2011), whānau-centred care focuses on the continuation of identity, tolerance, and belonging. This difference in understanding changes the whānau response to the kaumātua with mate wareware and shifts their expectations of care. Māori normalise mate wareware and adjust their lives around the kaumātua, supporting them to be involved in daily activities and cultural activities (Dudley et al., 2019).

The individualistic legal orientation to privacy and consent influences how staff and residents interact when Māori move into residential care that has not been designed from te ao Māori. Māori values are hegemonised into a Pākehā model of care, are simply not recognised, or devalued, irrespective of the organisation's good intentions. In addition, the communal living context of residential care offers opportunities for sexual expression that are not readily available to Māori when living with whānau. For tauīwi, people most commonly move from living independently into this communal environment as they become increasingly frail. However, in collective cultures, the move to non-whānau-provided care is significantly less likely to occur (Holdaway et al., 2021). The change to a residential care setting from a whānau care setting alters not only the context and values but also the people around them. Inherent in whānau care is the management of intimate relationships and sexual expression that uphold the mana of the kaumātua. With the absence of whānau involvement in everyday life, the focus on mana enhancement becomes dependent on kaimahi with differing worldviews who have not known the kaumātua prior to their cognitive decline.

Thus, layers of complexity encompass the lived reality for many Māori when considering consent, cognitive decline, and sexual expression alongside mana-enhancing care of kaumātua in residential care. These include the shift from a family environment to a non-relational communal one that does not reflect te ao Māori, new opportunities presented by a tauīwi-dominated communal environment, and the clash between Māori values and staff statutory responsibilities.

Methods

The original study was a national two-arm mixed-methods cross-sectional study conducted between October 2018 and October 2019. Survey respondents and interview participants

were recruited from 35 residential care homes. This article is written based on Māori responses to the survey and participants in the interviews. Research team members attended staff meetings at all facilities, providing refreshments and creating the opportunity for preliminary discussions about the study. Given the sensitivity of the topic, this process enabled sharing between researchers and staff and raised group awareness of commonalities around uncertainties and tensions about care decisions. Making time for mihi (formal greetings and introductions) and whanaungatanga (connections to people, ancestry, and place) appeared to pave the way for engagement with the study.

For the quantitative arm, the research team developed and validated a knowledge, attitude, and behaviour survey (Cronbach's alpha for the entire survey was .81). Surveys were distributed to staff at these staff meetings, with additional surveys left for staff unable to attend to complete. In total, 433 surveys were completed and returned from facilities throughout Aotearoa. From the surveys completed, it was found that 29 (6.7%) respondents identified as Māori, 281 (64.9%) identified as non-Māori, and 123 (28.4%) did not identify their ethnicity. The survey was anonymous and self-administered. The estimated overall response rate was 62.5%. Composite scores were developed for each domain and assessed. The data collected from the surveys were cleaned and coded, entered into statistical software for analysis, and the probability threshold set at $\alpha = .05$. Data were checked for accuracy, missing data, outliers, and normality before statistical analyses were conducted. Missing items were coded with a neutral response.

The qualitative arm consisted of semi-structured interviews with participants recruited from the same 35 residential care homes. Staff, residents, and residents' family members were invited to contact research team members if they were willing to be interviewed. Project staff conducted 75 interviews with staff, residents, and family members. Of the 24 staff interviewed, 5 out of 24 (20.8%) identified as Māori, and 1 of 26 (3.85%) residents interviewed identified as Māori. Despite our recruiting efforts, no family members interviewed identified as Māori. The lead author, a Māori researcher, conducted interviews with Māori and led the coding and analysis of Māori data informed by the work of Pere and Barnes (2009).

A social constructionist approach was used to obtain and analyse the qualitative data. This approach focuses on how meanings are created, negotiated, and interrupted (Burr, 2015). Each member of the research team analysed the raw data and then met as a team to discuss and agree on the key themes and their meanings in relation to the research question. This inter-reliability increased the rigour of the coding and data analysis (Fereday & Muir-Cochrane, 2006). The agreed meanings were then further tested with the advisory group as representatives of the aged residential care sector. Finally, the initial technical report was peer-reviewed by a community advisory panel, which included a kaumātua, experienced researchers, practitioners, and sexuality educators in the field.

The study was informed by *Te Ara Tika Guidelines for Māori Research Ethics* (Hudson et al., 2010) and approved

by a university Human Ethics Committee whose members were satisfied that the research team was appropriately culturally informed and had demonstrated expertise in sexuality research with marginalised people, such as those living with mate wareware. Regarding involvement of residents with cognitive impairment, we used the approach described by Brannelly (2011) to ensure that notions of protection did not exclude people unnecessarily. The interviews were conducted with participants kanohi ki te kanohi (face-to-face).

Results

Survey data: staff

Analysis of the survey findings shows interesting and statistically significant results that suggest a cautious approach by Māori to sexual intimacy as a right, the right to same-sex intimacy, and access to sex workers. We explore these findings below. The survey asked respondents to respond to the statement: Intimate relationships with pleasurable touch are a lifelong human right. Significantly fewer Māori respondents (19/29, 65.5%) agreed with this statement than Pākehā and tauwi (126/151, 83.4%; $p = .04$). Importantly, seven (24.1%) Māori respondents were neutral about this statement, which could suggest reluctance or a decision not to engage with the subject. A similar response profile emerged about same-sex sexual intimacy. Significantly fewer Māori respondents (13/29, 44.8%) agreed with the statement "Two male (or two female) residents have the right to be sexually intimate with one another" compared with Pākehā and tauwi who agreed (116/151, 76.8%; $p = .02$). Similarly, significantly fewer Māori supported facilities providing access to sex workers for residents (6/29, 20.7%) compared with Pākehā and tauwi (61/151, 8.3%; $p = .05$).

It is possible that the influence of Christianity through colonisation could be contributing to some of the reticence to discuss or acknowledge openly things of a sexual or intimate nature, although three-quarters of Māori respondents identified themselves as having "No religion". However, there is also a deeper understanding of wairua (spirituality) for Māori, which is related to the tapu (sacredness) that inheres to intimacy and sexuality. Within the wairua and tapu constructs, there is an understanding that there are greater forces than the individual and their individual rights or personal desires. Decisions to engage with intimacy and sexuality have impacts wider than the individual, and therefore what is important is wider than the individual (Mead, 2020).

Another area explored in the staff survey that demonstrated a significant and, on the surface, surprising result is well-being. Significantly fewer Māori (13/29, 48.8%) agreed with the statement "Sexual activity may improve older people's well-being and mood" than New Zealand (NZ) Europeans (111/151, 73.5%; $p = .007$). However, a greater proportion of Māori (15/29, 51.7%) than NZ Europeans (35/151, 23.2%) scored this question as "neutral", again suggesting that Māori might be unwilling

to engage with the topic. Linking sexual activity to well-being may be similar to dis-ease about what is private and tapu as discussed above, or it could be that the binary choice “agree/disagree” does not adequately reflect the complexity of how this issue is understood by Māori. Again, due to the lasting and profound impact of Victorian Christianity that came with colonisation, sexuality is not generally discussed openly in Māori circles, and often opinions for Māori come from a collective or whānau perspective view rather than from an individual (Aspin & Hutchings, 2007). If the subject is not openly discussed, then there is no collective viewpoint to offer. If an individual puts their own view forward independently, they could risk breaching tapu by contravening a collective viewpoint that has not been shared (Durie, 1998; Mead, 2020).

Responses to another well-being statement, “My main responsibility is to ensure that the people in my care are well and happy, even if this means allowing them to engage in sexual behaviours that their family members might not approve of,” reflected a similar sentiment. Only 8 of 29 (27.6%) kaimahi agreed that this is a staff responsibility, compared with 88 of 151 (58.3%; $p = .006$) Pākehā and tauwi staff. There is no doubt that well-being is important to Māori. However, the intent of the question was to force a choice about sexuality and well-being even in the face of family disagreement. Therefore, in analysing the response to this question, we must ask whether it is the well-being component or the whānau agreement component to which kaimahi responded. It could be that the phrase in this question “family members might not approve” suggested that a whānau perspective could be ignored, and this may have been troubling to Māori respondents.

From a Māori perspective, decisions about kaumātua well-being would be whānau decisions that would include the opinions of the kaumātua and may include input from staff. It would then be the staff responsibility to act according to that collective decision. Whānau have much to contribute to decision-making because they know the kaumātua for whom they have been through their lifetime and how they make their decisions. For example, if kaumātua are someone who have been active in tikanga and marae (a tribal meeting place), they would have a firm cultural foundation from which their decisions are made. Kaumātua would have their own boundaries, especially in relation to relationships, intimacy, and sexuality. The whānau would know this and would have a responsibility to support the kaumātua to maintain their tapu. In this way, they uphold the mana of that kaumātua, and it is then the responsibility of the kaimahi to respect that decision.

While initially these findings may be surprising given the common assumptions that well-being is equally, if not more, important to Māori than Pākehā and tauwi, because of the emphasis on whanaungatanga in te ao Māori, we believe that much deeper exploration of these complex issues will be essential to capture the nuance of Māori understandings. Well-being for Māori is inclusive of the person’s role and mana in the context of their whānau and their community. An intrinsic part of this is their whakapapa (ancestry) and future generations. It is clear the liberal

humanist values of well-being are at odds with te ao Māori. Hence, there is dissonance when Māori move into a communal living environment that has little or no understanding of the core of their well-being.

Interview data: staff

As we have set out above, it can be difficult for Māori whānau to associate the ageing person with intimate relationships when these kaumātua are leaders and often lead full lives centred on marae activity and their whānau, leaving limited time for private or personal relationships. The interviews with kaimahi provided insight into how kaimahi viewed caring for Māori kaumātua quite differently from tauwi residents especially when they knew the person in their life before the residential aged care setting. In the following quotation, two kaimahi wāhine (women) considered a situation that sometimes arose whereby a kaumātua with mate wareware might form what appeared to be an intimate friendship with another resident, but they have a living spouse. They deliberated on what would inform their decision to intervene and stop such a relationship developing:

It’s not so much a belief system [for me], to me it’s what I think is right. If their cognitive memory was working fine, would they do it? . . . It’s like you’ll be protecting that person, eh, because you’re working with them all the time; sort of like they’re your own, you wouldn’t want them to. (Kaimahi 9A)

This pair of kaimahi emphasised a traditional practice of gaining consensus among whānau and staff:

I would go with the consensus. If everything around it was right. Like I said, you’ve gotta take into account their mind, when their cognitive is sound. If they’re not, we still look into the situation and work around it and to support it if we feel that that’s where it needs to go we support. And, yeah, I’ll certainly stick with the consensus. . . . Consensus is very important to do with the people and also family, whether they agree, and just communicating all that to all of the rest of the staff, and how we all feel about it. (Kaimahi 9B)

Long-standing relationships for Māori varied between facilities and localities. In one area where there was a large Māori population, staff viewed their relationship with Māori in their care as a continuation of their being in the community, in how both the kaumātua and the whānau engaged with the facility:

Most of Māori don’t lose the relationship with the whānau or their partners, whether they’re here or not, they don’t lose it. Whereas [for] Māori that whānau relationship never ends, it never ends. So, regardless of whether they’re here or out there, it continues. They’re always used to having someone there with them, with our culture, right to the very end. Māori don’t lose the relationship with the whānau or their partners. (Kaimahi 9B)

In another facility and location, a kaimahi highlighted the intimacy around end-of-life care, with the longevity of

relationships evident. This was seen as a major difference between Māori whānau and Pākehā and tauwi families:

They don't always stay more connected while they're alive, actually, but when they're dying that's when you really notice a big difference in terms of that gathering and that support from a Māori family, from whānau, as opposed to where everybody gathers, no matter what—if you haven't seen Cousin X for the last 20 years, it doesn't matter, if they're dying, you turn up. And that's another form of intimacy I suppose. Whereas generally for our Caucasian people you'll find that it's generally just one or two close people who hold that vigil. (Kaimahi 1)

For some kaumātua, the relationship with whānau stayed the same: only the physical space changed. Staff in one facility were worried about the loneliness of a kaumātua who spoke te reo and they had no one who could kōrero (speak) with her. A senior kaimahi was at a tangihanga (funeral rites) and got talking to a kaumātua there and had the following conversation:

[H]e said, "You know, it's funny . . . I had an aunty . . . I lost track of her and I could never find her, and the family now are scattered to the four winds couldn't find her . . . But someone told me she was in [region]," and I went, "Oh okay . . . What was her name?" And he told me. I said, "Oh she's one of my patients." So, it was excellent, so he would come through from [region] and stay with me a couple of nights and then he would come in and he would just speak te reo to her, but he would bless all our rooms and bless all our staff. (Kaimahi 23)

Our data highlight the focus on a broad conceptualisation of intimacy that shifts with age to focus on ensuring the mana enhancement and protection of kaumātua and their connection with te ao Māori, including whānau and te reo.

Interview data: kaumātua

One kaumātua was interviewed in her room surrounded by photos of whānau, and her artwork and crafts. She spoke of this period of her life with deep contentment, focused on her spiritual world and interests, enjoying the freedom from her earlier commitments to a partner and young children, and with no desire to re-partner:

There was no adjustment [in moving to a tauwi-led residential care home]; I just flowed into it naturally. . . because my world is within me. . . I don't choose many friends at all because I feel my life is mine to do whatever I want to do now. As I said, I am doing other things. I can do what I want to do now. This is the time I use to develop my artistic side . . . It doesn't feel that I need one [a partner]. It's beyond that. I think having a male companion when you're young it's there that moment, but as you age it leaves you [desire for relationship] for more [spiritual] teachings I suppose . . . We had five children together . . . I wanted to learn all about the world and what's in the world for me, and how to develop my own gifts that I had been given by God. I wanted all that. And the time with a companion had passed. It's not a need anymore. It's a very satisfying life. The intimacy, that was there . . . but, I have left that place and moved on. (Kaumātua 20)

Although this kaumātua was clear that partnered intimacy held no interest for her, she spoke warmly about other residents she knew who had re-partnered within the residential care home:

She's got that companionship. It's only natural; a part of natural life. For me it's well and truly over, but for others no . . . there's one or two maybe it's not completely over for them. (Kaumātua 20)

This kaumātua perceived that partnered intimacy was associated with an earlier part of her life, closely associated with child-rearing. At this stage of life, her connection to her spiritual and creative life, with her children and other residents, was what enhanced her quality of life.

Discussion

With increasing age, the life focus of traditional kaumātua becomes more about upholding the tikanga of the marae and supporting events like tangihanga and marae-based celebrations. On the marae, koroua (male elders) and kuia (female elders) work in unison, complementing each other's role. Neither one is more important. For example, it is kuia who karanga (call, summon) visitors onto the marae and koroua who give the whaikōrero (speeches). These are roles that are generally undertaken by kaumātua, both koroua and kuia. Not all Māori achieve this status, especially those who are most impacted by colonisation and urbanisation, and who therefore live with some alienation from tikanga. It is essential for mana motuhake that the status of kaumātua is uninterrupted by the move to residential care. Hikaka and Kerse (2021) identified several residential care villages in Aotearoa that are exemplars of culturally responsive architectural design, policy, and staffing, aligned with te ao Māori and inclusive of tikanga and te reo in everyday routines, enabling the homes to be run in a culturally authentic way.

Kaumātua relationships are often formed in a way that supports this latter part of their life. For example, as kaumātua, koroua, and kuia may be in a partnership and have a strong relationship with each other, that is based on respect for the roles they hold as guardians of the kaupapa (focus, policy, protocols) rather than an intimate and personal relationship. The following example highlights such a relationship. The pair, well known to the first author, was an uncle (age 70) and his niece (age 75). Many people thought they were husband and wife because they travelled to almost all hui (gatherings) together supporting the teaching of tikanga, modelling tikanga, and upholding tikanga for many years after they had both retired. Both were widowed. The numerous meetings they attended often tired them, but they always considered what was important and saw each kaupapa to its natural end. They grew old doing this service and being loved and supported by a large and constantly growing supportive whānau and network. They constantly encouraged other kaumātua to join them and attendance grew. It also meant they set an example for attending other social functions such as kaumātua hui,

social gatherings, and other kaumātua activities provided by community health providers. For these kaumātua, the roles they played on the marae and in their world defined their relationship. It was an intimate relationship based on their individual lives as Māori and their status as holders and transmitters of tikanga and te reo. They cared for and respected each other and all those who were around them. Their intimacy was based on their intellectual, spiritual, and whānau connection rather than a physical, romantic, or sexual connection. For this uncle and niece, moving into a facility that operates from a western, statutory worldview, and having to address assumptions about them, could pose a real threat to the core of their being. Imposed sexualised or romantic assumptions radically underestimate and undermine the integrity and tapu of their relationship and their mana. It is essential for them to be able to maintain the intimacy of their relationship and to have its importance recognised, respected, and protected.

Not only is it the case that certain kinds of non-sexual intimacy may not be well-understood, intimate desires that are of a sexual nature can be difficult to discuss, as for many Māori openness about discussing things of a sexual nature and being clear about one's own sexuality have been clearly shaped by colonisation and the influence of Christianity (Aspin & Hutchings, 2007; Mikaere, 2005; Morison & Herbert, 2019). Wider use of mātauranga Māori in school-based sexuality curricula would ensure that rangatahi feel more prepared to make decisions in the context of te ao Māori (Le Grice & Braun, 2018). Such an approach may well impact future generations of Māori and how they engage with intimacy, sexuality, and the ethics of consent.

However, in the meantime, facilities that care for older persons need to change how they move forward with this knowledge (Hikaka & Kerse, 2021). It is critically important that as the number of kaumātua in residential care increases, the efforts to understand what is important to them also grow. This means that researchers, policymakers, and care providers need to respectfully engage with Māori to develop education, policies, and models of care that are founded in te ao Māori, and that mātauranga Māori is integrated into institutional care attitudes and practices (Dudley et al., 2019). Our experiences and findings suggest that further research is essential and will need to expand notions of consent that include a wide variety of epistemologies of consent in a post-colonial world. This will be particularly important in the context of residential care and even more so for kaumātua with mate wareware.

Conclusion

This study has identified a knowledge gap in understanding consent processes involving kaumātua who are living in residential care and their whānau. This means that kaumātua and their whānau are vulnerable to the often-limited cultural knowledge of care staff, the majority of whom identify as tauwiwi and whose care is guided by post-colonial individualist rights-based laws, ethics, and policies. Caregivers may encounter situations where they do not understand the

cultural nuances and complexities, and resort to their own individual values or institutional policies. The current literature provides scant direction for practitioners who want to engage with te ao Māori conceptualisations of consent that are mana-enhancing. Cognitive decline and mate wareware add another layer of complexity about who makes decisions and how decisions are made around intimacy and sexuality when the mana of the kaumātua may be at risk. Promoting deeper understanding about later life care is an urgent priority given the increasing life expectancy of all people, including Māori, and the ever-increasing diversity among Māori.

Recruiting kaumātua, whānau, and kaimahi to this study was complex, which was expected given the proportionately small number of Māori engaged with the aged residential care sector and their reticence to discuss topics of this nature. Greater understanding of the complexity of Māori values around consent, intimacy, and sexual expression in kaumātua may be achieved by a more focused exploration using kaupapa Māori. Based on these findings, we propose that it is important for kaimahi and Pākehā and tauwiwi caregivers to be familiar with providing culturally respectful care to kaumātua, and that the mana of kaumātua must be acknowledged and upheld in the residential care context. Kaumātua who have lived their lives immersed in te ao Māori need to be cared for by kaimahi and caregivers who understand what that means to the kaumātua, the whānau, and in the caregiving context; kaumātua who have lived more in the Pākehā world may find themselves searching for or reverting to more traditional meanings at the end of their lives. Mana-enhancing care can only be achieved by building relationships with kaimahi, kaumātua, and their whānau, which facilitate understanding and result in care that fully comprehends what is important to each kaumātua and their whānau.

Authors' note

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Mark Henrickson (PhD, RegSW) (he/him) is Professor of Social Work at Massey University, Auckland, Aotearoa New Zealand, where he has been since 2003. He worked for many years in HIV-related health and mental health care. He has published extensively on gender and sexual diversity and led a national study on HIV and Black African new settlers in New Zealand. He has undertaken consultancies throughout the Asia-Pacific region. His current research explores the ethics of intimacy and sexuality in residential aged care. Major recent publications include the edited book

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Catherine Cook (PhD, RN) (she/her) is an Associate Professor in the School of Clinical Sciences at Auckland University of Technology. Her clinical background is in nursing, midwifery, and counselling. She has for many years had clinical and research interests in the areas of sexuality, sexual health, and sexual identity, particularly as these issues relate to marginalised and vulnerable populations. The main questions driving Catherine's research are as follows: How do health professionals optimise health care, quality of life, and wellbeing for potentially vulnerable and marginalised populations, balancing both a duty of care and upholding rights? How does cultural diversity in teams shape ethical assumptions and communication about health care, quality of life, and wellbeing for potentially vulnerable and marginalised populations?

Vanessa Schouten (PhD) is a senior lecturer in Philosophy at Massey University. She completed her PhD at Princeton University in 2015. She works mainly in the area of sexual ethics and health care ethics, with a focus on intimacy. She is particularly interested in questions to do with consent: what it means to consent, when consent matters, and why it matters. The focus of her research is using insights gained from the experiences of those working in areas where tricky issues to do with intimacy and consent arise during the course of their work to inform both practice and theory.

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Glossary

Aotearoa	New Zealand
hui	gatherings
iwi	tribes
kaimahi	Māori care workers
kanohi ki te kanohi	face-to-face
karanga	call, summon
kaumātua	Māori elders
kaupapa	focus, policy, protocols
kōrero	speak
koroua	male elders
kuia	female elders
mana	authority, influence, power

mana motuhake	self-determination and sovereignty
marae	a tribal meeting place
mātauranga Māori	Māori knowledge
mate wareware	dementia
mihi	formal greetings and introductions
Pākehā	a New Zealander of European descent
tangihanga	funeral rites
taonga	treasure
tapu	sacredness
tauwiwi	non-Māori people
te ao Māori	the Māori world; the Māori worldview
te reo Māori	Māori language
Te Tiriti o Waitangi	The Treaty of Waitangi
tikanga Māori	customary system of Māori values and practices
wāhine	women
wairua	spirituality
whaikōrero	speeches
whakapapa	ancestry
whānau	Māori extended family
whanaungatanga	connections to people, ancestry, and place

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