To Tatou Hokakatanga:

Action and Intervention in Sexual and Reproductive Health

A Report Prepared for the Health Research Council of New Zealand

Prepared by
Te Puawai Tapu
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Dr Cherryl Smith & Dr Paul Reynolds

Te Puawai Tapu is a Kaupapa Maori health provider specialising in Maori sexual and reproductive health. Te Puawai Tapu provide Kaupapa Maori services, including sexuality education, policy and advocacy, and professional development training. As a Kaupapa Maori organisation, Maori realities and needs are central to any work that is undertaken, and any service provided.

Executive Summary

There Are Six Key Issues That Emerge From This Report:

1. Kaupapa Maori Provision For Sexual And Reproductive Health

There is a serious lack of kaupapa Maori provision for sexual and reproductive health. Te Puawai Tapu, based in Wellington, is the only kaupapa Maori provider that deals specifically with sexual and reproductive health. Other Maori providers had Maori workers dealing with sexual and reproductive health working within hauora, rangatahi and social services. Within that group they cover enormous areas/regions and populations e.g. Te Kaha o te Rangatahi Whanau o Tamariki Makarau Trust, which employs 6 Maori and Pacific peer educators based in South Auckland, provide pregnancy, parenting, self-esteem, sexual health and reproduction, and peer education support for the greater Auckland area.

2. Complexity Of Sexual And Reproductive Health

Sexual and reproductive health is complex and needs a broad range of responses in order to work toward positive outcomes for Maori. An important place to begin is to start to seriously engage with Maori communities in a range of ways. It is also important to acknowledge that sexual and reproductive health is life long and covers the full range of sexualities.

3. Sexual And Reproductive Health & Maori Statistics

The statistics for the area are incomplete, and for Maori are almost non-existent. Therefore the statistics we have do not give a true picture of how STI's and other sexual and reproductive health matters fully impact on Maori whanau. The picture we do have is alarming. Maori are represented in the worst statistics, with youth being particularly at risk. In 2001 43% of Maori were under 18. Approximately half the Maori population is under 23. (2003 Census).

The Ministry of Health highlights some of the statistics of sexually transmitted infections:

> "Current data show that overall rates for chlamydia, gonorrhoea and genital warts are highest in the 15–19 years age group. Rangatahi Maori appear to have higher rates of STIs than Pakeha, especially for chlamydia and gonorrhoea, both of which can have long-term impacts on health, such as ectopic pregnancy and infertility."[1]

Additionally, the 2005 annual surveillance report from ESR reveals that over 70% of those with concurrent (multiple) infections were aged less than 25 years and Maori were approximately two times and Pacific peoples three times likely to have concurrent infections.[2]

From the research that we have completed with Maori sexual and reproductive health providers, there is anecdotal evidence that this disparity in health statistics is continuing to increase. The worst-case scenario we predict is that we are looking at an infertility crisis for Maori in the coming years.

4. Concern With The Stigmatising And Problematising Of Maori Fertility

What our research shows is that Maori communities are deeply concerned with the stigmatising and problematising of fertility e.g teen pregnancies once young women have fallen pregnant. There is a long history to Maori non-involvement with fertility control and early childcare agencies because of Maori being categorised as 'unfit' which this report backgrounds.

1 Ministry of Health tender for policy advice paper, June 2006.

2 In the quarterly ESR clinic surveillance of STIs in NZ for 2006 Maori have higher rates of infection of gonorrhea and chlamydia than European/Pakeha and Pacific peoples.

5. Kaupapa Maori Services

The key to addressing effective community interventions lies in the expansion of 'By Maori for Maori' services which are able to address access and information dissemination issues. Providers need access to kaupapa Maori sexual and reproductive health training and information. There is a need to work with whanau - rangatahi live within whanau in their communities (rangatahi daily connect with – siblings, parents, cousins, foster and step siblings, marae groupings, kapa haka groupings, sports groups etc as well as school groups). The focus on the individual doesn't work for Maori and is not intergenerational (i.e. current focus is on youth) or whanau focused.

6. Schools And Sexual And Reproductive Health

There is very little consistency across schools of time, knowledge and interest in the area of sexual and reproductive health generally, let alone how to deal with Maori views of sexual and reproductive health. Teachers now are delivering sexual and reproductive health education or contractors are brought in. Teachers need professional development to teach in the area. There is very little that takes account of the needs of Maori students within schools. Unless a kaupapa Maori provider comes into that school, or a Maori nurse or educator, there is little recognition of different cultural frameworks. Schools see health differently and implement differently; some see it holistically and some see it as something you add a bit on.

Introduction

At the first Maori Sexual and Reproductive Health Conference held in November 2004, Maori M.P, Tariana Turia made a speech that was to cause a media furore. She pointed out that as far as she was concerned all children should be welcomed and that she was intolerant of the excessive focus on Maori fertility rates and the condemnation of the fertility rate of young Maori. Statistics were showing a 26.2 per 1000 birth rate for Maori 13-17 years of age, five times the rate of Pakeha. She stated at the conference that Maori fertility had been controlled and that she didn't agree with it. She told Maori that there had been brainwashing to believe that having more than two children was wrong. Her speech was highly approved by the Maori audience that was present, a gathering of the key Maori sexual and reproductive health educators. The media and other politicians criticised her speech calling her irresponsible and approving of teenage pregnancies. The speech and the differing reactions from the Maori audience and the media showed up a clear difference in understanding and knowledge.

To understand the comments and the apparent approval of Maori at the conference it is important to look at history. There is a long history of Maori resistance to organizations such as Family Planning, Plunket and others that is often not understood. What many current policy makers, analysts, Ministries, media, and non-Maori sexual and reproductive health agencies have failed to take into account is that there is a history of Maori being considered 'unfit' which is outlined in this report.

The first known sexually transmitted diseases to affect the Maori population were thought to be brought on the first boats that came from Europe and England, where venereal disease and syphilis were carried by the first explorers. The impact of imported diseases and wars over land and sovereignty took such a toll on Maori that the population fell to approximately 40,000 people at the turn of the 20th Century. At that time it was said that Maori were a 'dying race'. Despite this history, Maori fertility rates began to climb in the 20th Century. The latest New Zealand Census statistics (2006) put the Maori population at approximately 15%. But the regeneration of the population has left a general sense that whakapapa and its continuity is of key importance for whanau, hapu and Maori generally. He aha te mea nui o te ao? He tangata, he tangata, he tangata! For that reason discussions of fertility and fertility control need to be viewed in this historical context.

Currently within sexual and reproductive health there is overwhelming statistical evidence of serious disparities in sexual and reproductive health outcomes between Maori and non-Maori. Maori are experiencing a high incidence of sexual activity at a young age, high rates of teenage pregnancy and abortion, and high rates of STI's such as Chlamydia and gonorrhoea, with young Maori having a high incidence of concurrent (multiple) infections. The long-term impact on health of high rates of chlamydia and gonorrhoea in the Maori population is infertility. The worst-case scenario we predict is that we are looking at an infertility crisis for Maori in the coming years.

Sexual and reproductive health is therefore an area of significant concern for Maori. The historical context of sexual and reproductive health for Maori relates to the processes of colonization and the Eugenic policies of control of Indigenous populations. The contemporary state of sexual and reproductive health for Maori must be seen in this historical light.

Introduction To The Research

This research project, "To Tatou Hokakatanga: Action and Intervention in Sexual and Reproductive Health," provides a kaupapa Maori analysis of the area of sexual and reproductive health. It provides a critical focus on understanding disparities and informing the development of interventions appropriate to meeting the sexual and reproductive health needs of Maori.

Key questions asked in this research are:
What is kaupapa Maori?
How does kaupapa Maori relate to sexual and reproductive health services?
What historical factors influence the way that Maori think about sexual and reproductive health?
What is the traditional base from which Maori talk about sexual and reproductive health?
How are Maori sexual and reproductive health workers doing?
Is the political context conducive to the development and expansion of kaupapa Maori health provision?

Because this report represents the first significant piece of research that has focused on Maori sexual and reproductive health it was necessary to do some considerable groundwork. The groundwork involved bringing together literature and talking to a range of key groups. Key groups included; experts in te reo me ona tikanga, Maori sexual and reproductive health providers, kaupapa Maori experts and policy experts.

Kaupapa Maori research acknowledges the power of communities to initiate and develop interventions, actions and theory. For that reason those workers who have initiated and developed this field were considered experts in Maori sexual and reproductive health even though they are learning as they go. The Kaupapa Maori sexual and reproductive health field is relatively new, having developed largely over the last ten years. It has had to develop in an ad hoc way with few resources. It has arisen as a direct result of the need of Maori to respond to the lack of Maori specific service and education provision in sexual and reproductive health.

Current Policy Context

Sexual and reproductive health in New Zealand has only recently been recognized as an area of importance in government policy. This recognition has been largely influenced by the international responsibilities and obligations of governments operating within the international community of world powers.

Currently there is a review of a number of areas related to sexual and reproductive health in New Zealand. The New Zealand Education Curriculum is currently under review; the curriculum has not been revised since the 1999 version came into effect. Additionally, the Ministry of Women's Affairs is leading a cross-agency review of sexuality education in New Zealand secondary schools to gather information on how schools and communities are implementing sexuality education. The review will be conducted by ERO and is expected to be complete by the end of 2006. Pupils in years seven to 13, from a sample of 80 – 100 schools, will be included in the review.

In June 2006 the Ministry of Health called for submissions from interested parties to provide an advice and discussion paper on the development of policy and service advice on gathering Maori sexual and reproductive health information, in particular to identify strategies on how best to meet the needs of Maori public health providers working in the area of sexual and reproductive health. On December 4 2006, the New Zealand Parliamentarians Group on Population and Development (NZPPD), a multi-party group of politicians, invited government agencies, non-governmental organizations, and other professionals from youth, health and education services to present oral submissions to an open hearing on Youth Sexual and Reproductive Health.[3]

The Government also specifically acknowledges the importance of sexual and reproductive health. Government responsibility for achieving sexual and reproductive health for all New Zealanders is underpinned by compliance with various international instruments. The New Zealand government has ratified a number of international treaties that adopt a 'rights-based' approach to sexual and reproductive health. As part of its responsibility for achieving sexual and reproductive health, the New Zealand Government released a strategy for sexual and reproductive health development. The Strategy outlines a two-phase approach to addressing identified key issues in sexual and reproductive health, including reducing sexually transmitted

3 The authors of this report provided an oral submission on behalf of Te Puawai Tapu on the findings from this research report.

infections (including HIV/AIDS), sexual abuse and unwanted / unintended pregnancies, and maximising the health of at-risk groups, including Maori (Ministry of Health 2000, iii).

In 2001 phase one of the Sexual and Reproductive Health Strategy was initiated and indicated the overall direction the Government wished to take to achieve positive and improved sexual and reproductive health for all New Zealanders. The Ministry of Health established a Sector Reference Group made up of a group of independent experts in the field to help develop the sexual and reproductive health strategy for New Zealand. Phase one provided the guiding principles and outlined the strategic direction. The Sexual and Reproductive Health Strategy identifies a crisis in Maori sexual and reproductive health and identifies Maori as 'a group of people most at need' and therefore one of the key priority areas for the Strategy (Ministry of Health 2001, 2).

In 2003 the Ministry began the second phase of the strategy, focusing on District Health Boards and Primary Health Organisations and the role they play in improving the sexual and reproductive health of their communities. Phase two involved the development of a resource book for New Zealand health care organizations and an HIV/AIDS Action Plan. The two Ministry-produced resources provided guidance for specific action plans for managing STIs, addressing unwanted/ unintended pregnancy and HIV/AIDS.

The need for the development of a high quality research base has also been identified within the Strategy. The Strategy notes that accurate and timely information is an essential health tool for improving clinical and professional practice (Ministry of Health 2001, 11). It is also fundamental for evaluating interventions and monitoring progress. Accurate and timely information is equally critical to informing the development of effective interventions for Maori sexual and reproductive health development. However, information about sexual and reproductive health status and behaviour in New Zealand is incomplete (Ministry of Health 2001, 13). Furthermore there is 'limited existing reliable research on Maori sexual wellbeing and reproductive health' (Ministry of Health 1997).

Research Timeline And Aims

This research project contract underwent some significant changes in its life from 2002 until the end of 2006. The initial Principal investigator and research personnel undertook the research from the inception of the project in 2002 until mid-2006. They completed the following:

1. A survey of Maori sexual and reproductive health service providers conducted toward the end of 2003.
2. Kaupapa Maori workshop/forum/conference with Maori sexual and reproductive health service providers, and other sexual and reproductive health stakeholders, including the Maori Sexual and Reproductive Health Workforce Development Forum held in November 2003 and the first National Maori sexual and reproductive health conference held in November 2004.
3. A comprehensive bibliography of sexual and reproductive health theory and literature.

In mid-2006 there was a change in the Principal Investigators and research personnel with the successful recruitment of two senior Maori researchers. This change in personnel in turn redefined the project.
The authors of this report have kept to the original aims of the research project, which was to develop a Kaupapa Maori analysis of sexual and reproductive health that will identify components of a Kaupapa Maori framework for sexual and reproductive health, and, to consult with Maori working in the sector to identify the sexual and reproductive health needs of Maori, including enabling factors and barriers to addressing these needs.

THE WRITERS OF THIS REPORT COMPLETED THE FOLLOWING:

1. Key informant interviews (one-to-one interviews and focus groups) were conducted with 27 Maori health providers and participants with knowledge and expertise in Maori sexual and reproductive health, identifying the sexual and reproductive health needs of Maori, including enabling factors and barriers to addressing these needs. The interviews or focus groups took place across the country and were conducted by the Principal investigators, and a te reo Maori interviewer. A semi-structured interview guideline was developed with interviews taking approximately 1-2 hours to complete, which were audio taped and transcribed. The transcripts were sent back to participants for editing and correction. The interviews and focus groups were analysed by the Principal investigators for recurring themes, additional issues and more in-depth explanation of issues.
2. A review of Kaupapa Maori theory as it relates to sexual and reproductive health. The Kaupapa Maori analysis identified key Maori sexual and reproductive health needs as identified by Maori. The Kaupapa Maori analysis of

sexual and reproductive health provided a sound basis for identification of the components of a Kaupapa Maori framework for action and intervention in sexual and reproductive health.

3. A review of scientific theories that have historically underpinned sexual and reproductive health and Maori.
4. A review of policy and approaches to sexual and reproductive health, including the impact of the international context on New Zealand sexual and reproductive health policy and strategy.
5. A comprehensive bibliography of sexual and reproductive health in New Zealand, eugenics and Indigenous Peoples, Kaupapa Maori, and Maori and sexual and reproductive health literature.

The key informant interviews (one-to-one interviews and focus groups) were conducted with 27 Maori health providers and participants with knowledge and expertise in Maori sexual and reproductive health. The age range of participants was from early twenties to late sixties/early seventies. The interview participants included:
4 Te reo Maori expert interviews
4 interviews with kaupapa Maori experts
3 interviews with policy & other experts
14 interviews with Maori sexual and reproductive health providers from Wellington, Auckland, Hamilton, Whanganui.
2 interviews with Indigenous scholars from Canada and the United States.

Scope Of The Report

This report provides a Kaupapa Maori analysis of the area of sexual and reproductive health, with a critical focus on understanding disparities and informing the development of interventions appropriate to meeting the sexual and reproductive health needs of Maori. The report includes an overview of relevant sexual and reproductive health literature (including an overview of some STI data), a chronology of sexual and reproductive health policy in New Zealand, an overview of the international context to sexual and reproductive health, an overview of service provision, and an analysis of indepth interviews conducted with providers, Kaupapa Maori and Policy experts, and kuia and kaumatua. The report offers recommendations on how to meet the sexual and reproductive health needs of Maori.

The report however does not cover an indepth look at all the different areas that make up sexual and reproductive health, including:

- The broader areas of sexual and reproductive health such as abortion, prostitution, sexual abuse, fertility and infertility
- A comprehensive analysis of the general literature on sexual and reproductive health, focusing primarily on what has been written by Maori and for Maori
- A comprehensive review of statistical data related to Maori, largely because the statistics that are available are incomplete;
- An Indigenous international comparison of sexual and reproductive health
- An international comparison of sexual and reproductive health service provision
- A comprehensive sexuality and gender theory analysis
- A comprehensive analysis of Maori health/hauora service provision, concentrating only on Maori sexual and reproductive health providers

We also did not talk directly to rangatahi about sexual and reproductive health, only to Maori sexual and reproductive health providers, particularly peer educators.

Composition Of The Report

This Report Is Divided Into Four Main Parts:

PART ONE Context – *Literature, Policy, National And International*

Part One sets the context for the whole report. The first sections critically focus on understanding Maori health and health disparities research, an overview of relevant Maori sexual and reproductive health literature and some STI data, and an overview of takataapui research. There is also a section outlining sexual and reproductive health policy in New Zealand, and an overview of the international context to sexual and reproductive health, which includes a number of international declarations that the New Zealand Government is a signatory to. The final section includes excerpts from two interviews with an Indigenous researcher and health provider, explaining sexual and reproductive health from an Indigenous historical and contemporary perspective.

PART TWO Analysis – *Historical And Contemporary Analysis*
This part of the report is entitled 'A History of Fertility and Maori.' It is important to analyse the history of fertility as it relates to Maori and Indigenous Peoples because it is strongly linked to colonization of Indigenous Peoples worldwide. Sexuality and reproduction has been of intense interest in the process of colonising Indigenous Peoples. As colonised peoples, population control and social control were part and parcel of colonising. This part provides an analyses of: eugenics definitions and theory, New Zealand and eugenics, the international history of eugenics, Indigenous and eugenics, and biotechnologies and eugenics. This part of the report goes some way to unravelling the history of eugenics and scientific beliefs that drove the discrimination against 'the unfit' and the control of fertility in New Zealand.

PART THREE *Maori Sexual And Reproductive Health Workers*
Part Three begins with an explanation of a 'Kaupapa Maori model of sexual and reproductive health' – which is a critique of the Western model of sexual and reproductive health, and the acknowledgement that reproductive and sexual health is sourced within a general philosophy of 'health', which needs to be revised before the specific field of reproductive and sexual health can be addressed. Part Three also includes an overview of Maori sexual and reproductive health service provision, incorporating a survey of the Maori workforce and critical discussions that were held with Maori providers of the barriers and gaps in service provision and policy. Part Three also includes excerpts from indepth korero held with Maori providers discussing their mahi and all of the issues related to their mahi as Maori sexual and reproductive health workers, as well as policy experts. The korero has been presented thematically and in block quote form in order for the reader to fully engage with the korero of the providers, and so the reader can 'hear' their 'voice.'

PART FOUR *Kaupapa Maori Sexual And Reproductive Health*
Part Four presents excerpts of indepth korero held with kuia and kaumatua and other tikanga experts, as well as service providers and Kaupapa Maori and Policy experts. The first section pulls together interviews/writings that give an introduction to the depth and breadth of hapu and iwi knowledge that exists when Maori sexual and reproductive health is talked about, in particular in relation to the question, 'What is the traditional knowledge of Maori about sexual and reproductive health?' Each of the speakers raises points that contribute to the ongoing korero that exists in different rohe. They also ask critical questions and talk about further discussion and research that needs to happen in this area. This part also includes a section on critically engaging in korero about what is considered Kaupapa Maori, and considering what a Kaupapa Maori provider and service would look like.

The report ends with the 'Key Findings' and 'Recommendations.' Additionally, the authors have appended a comprehensive bibliography that has been divided into three main sections: General bibliography; Sexual and reproductive health theory and literature; A history of fertility (Eugenics) bibliography.

Glossary

Below are some of the key terms that are used in this report and their meanings:

'Whanau' as opposed to 'family'
Whanau / Whanaungatanga / whakawhanaungatanga
Extended family, also means to give birth. In this report we use whanau to include the richness and diversity of Maori relationships that create whanau - not just nuclear, heterosexual and legally married. Whanau is inclusive of extended family, and the fact that we have a whakapapa connection to all things and are kaitiaki for all we hold dear.

Whangai
Child raised by the extended whanau or others. There is a section in this report that elaborates on a deeper explanation of whangai from a review of Ngati Kahungunu manuscripts.

Whare tangata
The house of people, the womb.

Takataapui / Takataapui
An intimate companion of the same sex. This doesn't allow for transgender or that someone may be alone.

Hauora
Health and wellbeing, which includes sexual and reproductive health. "Hau" is the life breath, the life essence of humans.

Kaupapa Maori provider
A Kaupapa Maori organization / provider takes for granted that Maori realities and needs are central to any work that is undertaken, and any service provided.

CONTEXT

PART ONE

Maori Health Research and Sexual and Reproductive Health Literature

There is very little literature written by Maori that concentrates on Maori sexual and reproductive health. There are also few statistics that show the impacts specifically on Maori. The few statistics that do exist tell us that Maori sexual and reproductive health is much worse than non-Maori. There could be a number of reasons for the limited writing in the area of Maori sexual and reproductive health. The experience of the establishment of Te Puawai Tapu showed that there was resistance among some Maori communities to talking directly about sex and sexuality, particularly western de-sanctified, medicalised approaches. Another reason could be that Maori sexual and reproductive health is not seen as distinct from Maori health and wellbeing in general. Sexual and reproductive health is just one of many influences on the wellbeing of the body, mind and spirit of a person, whanau, hapu and iwi. There has been the development however of a growing Indigenous and Maori voice on takataapui and sexuality research. What is encouraging also is that there is a growing body of literature produced by Maori on Maori health in general.

Maori Health: Widening Disparities

In the report, "Decades of Disparities III: Ethnic and socio-economic inequalities in mortality, New Zealand 1981 – 1999," the authors, Bridget Robson & Tony Blakely state, "An overview of the health trends shows that since the mid-1980s disparities between Maori and non-Maori have increased significantly as measured by a number of key health indicators: life expectancy, cancer mortality and cardiovascular rates. Research also shows a disturbing trend in the provision of health services, higher levels of Maori ill-health do not correspond with access to health services, e.g., despite the high mortality from heart-disease among Maori and Pacific peoples, cardiac interventions are most frequently received by non-Maori, non-Pacific peoples."[4]

The authors believe the causes of inequality must be addressed in order to make any improvements in health. The root causes are identified as colonisation and racism. In addressing inequalities, Robson and Blakely say, "… interventions at the structural level will be the most effective and sustainable way of reducing inequalities. The interdependence of the education system, the labour market, and the welfare state means that New Zealand's tax and transfer policies, and the way they are implemented, require careful evaluation of their effect on Maori economic status and the flow-on health impacts. Significant widening of gaps between Maori and non-Maori in education, employment, income, and housing since the economic restructuring signal a failure of the welfare state."[5]

In a recent study looking at the affects that racism may have on the health of Maori in the New Zealand health system,[6] Martin Tobias (Ministry of Health, New Zealand), and colleagues assessed the effect of racism on health in Maori and Europeans in New Zealand. The researchers analyzed 4108 Maori and 6269 European survey responses to five questions relating to physical or verbal attacks, and their treatment by health professionals and colleagues at work, or how they were treated when buying or renting a house. It was found that Maori were almost ten times more likely to experience discrimination. The authors state, "Racism, both interpersonal and institutional, contributes to Maori health losses and to inequalities in health between Maori and Europeans in New Zealand. Interventions and policies to improve Maori health and address these inequalities should take into account the health effects of racism."

A 2002 Public Health Intelligence (PHI)[7] report of indicators of New Zealand health provides a similar scenario. Although four years old, this table provides a comprehensive overview of the state of health of New Zealanders by utilising international indicators of health grouped into levels of causation; socioeconomic and environmental determinants of health, risk-factors, and outcomes (health outcomes affecting all of life and those affecting particular life cycle stages).[8] The PHI report highlights

4 Bridget Robson & Tony Blakely (May 2006). Decades of Disparities III: Ethnic and socio-economic inequalities in mortality, New Zealand 1981 – 1999. University of Otago & Ministry of Health. Page 3.

This is the second of two background papers produced for the Public Health Advisory Committee on the economic and socioeconomic determinants of health. This paper was commissioned to review evidence of the economic determinants of Māori health and disparities. See also Bridget Robson (June 2004). "Economic determinants of Māori health and disparities: A review for Te Röpü Tohutohu i te Hauora Tümatanui (Public Health Advisory Committee of the National Health Committee)." Te Röpü Rangahau Hauora a Eru Pömare, Wellington School of Medicine and Health Sciences, University of Otago. Page 3.

5 Ibid.

6 Harris R, Tobias M, Jeffreys M, Waldegrave K, Karlsen S, Nazroo J (2006). Effects of self-reported racial discrimination and deprivation on Māori health and inequalities in New Zealand: cross-sectional study. The Lancet - Vol. 367, Issue 9527, 17 June 2006, Pages 2005-2009.

7 Public Health Intelligence (PHI) carries out the Ministry of Health's statutory responsibility in monitoring the state of the public health of the country through four interconnected workstreams: surveys, health geoinformatics, modelling and forecasting and surveillance.

8 Public Health Intelligence, Ministry of Health, (2002). "An Indication of New Zealanders' Health: Public Health Intelligence Occasional Report No 1." See the full table from the report in the Appendix section of this report.

that in almost every indicator Maori fare worse than non-Maori; for example in the areas of obesity, prevalence of diabetes, prevalence of smoking, life expectancy, infant mortality rate, whooping cough and meningococcal disease notifications in children, hearing failure in children, teenage fertility, youth suicide, Ischaemic heart disease mortality, lung cancer incidence, cervical cancer mortality, tuberculosis, and stroke mortality.

The fact that there are significant health disparities has been well documented by Maori researchers, the Eru Pomare Research Centre and Dr Papaarangi Reid from Auckland University Medical School. In almost every major disease category Maori experience more death, illness, disability and risk. (Reid and Robson: 2006)

Maori Sexual and Reproductive Health: What Existing Research Tells Us

It is acknowledged in the 1997 Ministry of Health report, "Rangatahi Sexual Wellbeing and Reproductive Health: The Public Health Issues," that "Rigorous research by, for and with Maori is needed on all aspects of rangatahi sexual wellbeing and reproductive health issues. Although some literature exists on rangatahi pregnancy issues (Rolleston 1991; Ropiha and Middleton 1993; Harris 1994), there is little on rangatahi sexual wellbeing and health."[9] Unfortunately this is still the case today. There is very little research that has been conducted by, for and with Maori.

A literature search of recent Maori-specific research on sexual and reproductive health revealed few documents, most prominent being: *Rangatahi Sexual Wellbeing and Reproductive Health* (Ministry of Health 1997); a Masters thesis completed in 1998 by Tania Pouwhare entitled, "Safer Sex? Young Maori Women's Experience of Sex, Coercion and Contraceptive Use."[10]; and in 2002 Terryann Clark completed her Masters thesis entitled, "Young Maori attending alternative education: A profile of sexual health behaviours and associated protective factors."[11]

Jackson (2004), who completed a comprehensive literature review and study on sexual health in New Zealand, highlights the dearth of Maori research in this area. "Across all areas reviewed thus far, there is a significant gap in published research on young Maori, despite the fact that teen pregnancy and STI rates are particularly high among this group. Indeed, the birth rates for young Maori women are reportedly five times higher than for young Pakeha women, for whom rates are high but comparable with several other Commonwealth countries (Dickson et al. 2000). A good number of the available publications on risk factors and sexual behaviour have been drawn from the Dunedin and Christchurch developmental studies. Neither of these significant cohort studies included a representative sample of Maori. Some publications either fail to specify ethnicity in any helpful way (e.g., Davis and Lay Yee 1999) or to mention it at all (e.g., Romans et al. 1997). A few studies have sought to include representative samples of Maori (e.g., Allen 2001, Fenwicke and Purdie 2000, Lungley et al. 1993), although processes and methodologies seem to be the same for Maori and Pakeha. In contrast, Elliott and Lambourn (1999) describe the development of a peer sexuality education programme that clearly respected the status of tangata whenua and incorporated taha Maori into the programme. Although more research is needed to realise the important goals of enhancing the sexual health status of young Maori, it is surely Maori who should guide the issues researched, how the research is conducted, and by whom. Several kaupapa Maori research projects on sexual health issues for young Maori are currently under way and will provide much-needed understandings about the ways forward for addressing Maori youth sexual health concerns."[12]

The literature search also revealed that, not only is there a dearth of research and information on Maori sexual and reproductive health, but what is available often includes no, limited, or extremely problematic, analyses of Maori sexual and reproductive health (Dickson et al 1993, Dickson et al 1996, Dickson et al 1998, Davis Lay-Yee 1999, Fergusson and Woodward 2000a, Ferguson and Woodward 2000b, Paul et al 2000), as identified also by Jackson (2004) above. That is, the research that includes information regarding Maori sexual and reproductive health fails to provide analyses beyond description of statistical information (Davis and Lay-Yee 1999, Dickson et al 2000, Fenwick and Purdie 2001), documentation of sexual activity, (Fenwick and Purdie 2001, Lynskey and Fergusson 1993) contraceptive use, (Lynskey and Fergusson 1993) and STI rates (Dickson et al 1996). The resultant conclusions from this research merely show disparities between Maori and non-Maori in sexual and reproductive health outcomes.

9 Ministry of Health, (1997). "Rangatahi Sexual Wellbeing and Reproductive Health: The Public Health Issues." Page 61.

10 Pouwhare, Tania, (1998). 'Safer Sex? Young Maori Women's Experience of Sex, Coercion and Contraceptive Use,' Unpublished MA Thesis, Auckland University.

11 Terryann Clark (2002). Young Maori attending alternative education: A profile of sexual health behaviours and associated protective factors. Unpublished Masters Thesis. The University of Auckland. Page 104.

12 Sue Jackson (2004). "Identifying Future Research Needs for the Promotion of Young People's Sexual Health in New Zealand." Social Policy Journal of New Zealand - Issue 21 March 2004.

The following studies show there is overwhelming evidence of serious disparities in sexual and reproductive health outcomes between Maori and non-Maori:

- A study of 654 fourteen year old students in Hawke's Bay found that Maori students were nearly three times as likely as European students to be sexually active (Fenwick and Purdie 2001)
- Rates of births to teenage mothers (15-19 years) in New Zealand are higher than most other OECD countries (Dickson et al 2000). Teenage pregnancy is more common among Maori women. In 1998, the fertility rate for Maori females aged 13 – 17 years was more than five times that of non-Maori (Dharmalingham 1997 as cited in Sexual and Reproductive Health Strategy 2001).
- In 1999 Maori women (as well as Pacific and Asian women) had higher rates of abortion than the national average, and the European rate (Abortion Supervisory Committee 2000).
- While the data set for sexually transmitted infections is incomplete, a disproportionately high percentage of bacterial STI's (chlamydia and gonorrhoea) are reported among Maori and Pacific peoples. Multiple infections were more common from the period 1996 – 2000 for people aged under 25 years, as well as for Maori and Pacific peoples (Turley et al 2000)
- The incidence of chlamydia diagnosed at sexual health clinics is disproportionately high among Maori compared with incidence that might be expected based in the proportion of Maori reported in the 1996 census (Turley et al 2000).
- The number of people diagnosed with gonorrhoea at sexual health clinics has been increasing since 1996. Of the total 492 cases, 50% were Maori, (28% European and 16% Pacific peoples)(Turley et al 2000).
- The 1998 rate of hospitalisations for ectopic pregnancy for Maori females represents a rise of almost 25% from 1996. In contrast, the rates for European females and females of other ethnicities decreased by 10% (Ministry of Health 1999). This indicates the exposure of Maori women to STI's as well as inadequate treatment. It has human costs in terms of later infertility, as well as economic costs to the health sector.

Disparities research at times can be used to "blame" Maori individuals and whanau. A report on the analysis of teenage pregnancy and parenthood describes 'Maori ethnicity' as an individual risk factor associated with 'increased risk of early pregnancy' (Woodward et al 2001, 303). Reid et al described this type of analysis as 'victim-blaming' or 'deficit thinking' (Lykes et al 1993, Pihama 1993, Valencia 1997) whereby the analyses typically represent "Maori behaviour, genes, culture, socio-economic status and engagement with services as the 'problem'" (Reid et al 2001, 9).

This 'deficit theory' location of Maori as the 'delinquent other' compared to the European 'normality' prescribes a range of interventions that will seek to change Maori behaviour and attitudes to be like the European 'norm'. Besides being assimilationist, these interventions will likely work better for Europeans than for Maori and thus serve to increase disparities rather than to help to eliminate them. The need to move from deficit theory based analyses to those centered around Maori needs and norms has contributed to the development of kaupapa Maori models of research and practice (Smith 1999).

In support of this shift, Smith and Reid have argued that 'mainstream approaches do not work for Maori' (Smith and Reid 2000, 22). Maori health development requires approaches to sexual and reproductive health that are identified, developed and undertaken by Maori. Central to the notion of Maori health development is control. Mason Durie maintains '…unless Maori themselves are active in developing policies for health and bringing effective health services to their own people, then no amount of expert advice will provide the conviction of ownership' (Durie cited in Smith and Reid 2000, 20)

In more recent statistics we are still able to see the disparities in sexual health. In the 2005 Annual STI Surveillance Report from ESR, 'at-risk groups' include youth and non-Europeans.

> "As in previous years, those aged less than 30 years and non-Europeans were disproportionately burdened with STIs in 2005. This finding is consistent across most STIs, and is also seen in the SHC [Sexual Health Clinic] data on concurrent infections. Over 70% of those with concurrent infections were aged less than 25 years, and Maori were approximately two times and Pacific peoples three times more likely than Europeans to be diagnosed with concurrent infections. Similarly, complicated chlamydia and gonorrhoea infections, i.e. those resulting in PID or epididymitis, were more common in young people and in individuals from non-European ethnic groups."[13]

13 "Sexually Transmitted Infections in New Zealand: Annual Surveillance Report 2005" Prepared as part of a Ministry of Health Contract for scientific services by STI Surveillance Team, Population and Environmental Health Group, Institute of Environmental Science and Research Limited, April 2006, page 31.

The following ESR table of Sexual Health Clinic data, which includes between 23 and 27 participating clinics each year, reveal statistics gathered from 1997 to 2005 that show that Maori have been more significantly affected by STI's such as chlamydia and gonorrhea, than non-Maori.

ESR Sexual Health Clinic Data of Chlamydia and Gonorrhoea Infections, 1997 – 2005[14]

Disease	Ethnicity Sex	Rate type	1997	1998	1999	2000	2001	2002	2003	2004	2005
Chlamydia*	Maori Female	Crude	135.3	165.7	171.3	221.7	262.4	259.3	268.6	280.0	294.4
	Non-Maori Female	Crude	36.9	44.5	44.6	51.8	57.3	65.6	71.4	75.3	77.9
	Maori Male	Crude	102.5	116.5	125.8	136.4	160.2	147.1	168.8	172.4	162.9
	Non-Maori Male	Crude	46.5	46.3	46.1	57.9	63.8	64.6	73.6	74.5	85.8
	Maori Total	Crude	119.2	141.5	148.9	179.7	212.0	204.0	219.4	227.0	229.5
	Non-Maori Total	Crude	41.6	45.4	45.3	54.7	60.5	65.1	72.4	74.9	81.8
	Maori Female	ASR**	135.3	165.7	171.3	221.7	262.4	259.3	268.6	280.0	294.4
	Non-Maori Female	ASR**	51.2	61.7	60.6	69.5	77.7	88.5	95.0	99.7	103.9
	Maori Male	ASR**	102.5	116.5	125.8	136.4	160.2	147.1	168.8	172.4	162.9
	Non-Maori Male	ASR**	55.1	55.1	54.0	67.9	74.6	75.0	83.3	82.8	95.0
	Maori Total	ASR**	119.2	141.5	148.9	179.7	212.0	204.0	219.4	227.0	229.5
	Non-Maori Total	ASR**	53.1	58.4	57.4	68.8	76.2	81.9	89.3	91.4	99.6
Gonorrhoea*	Maori Female	Crude	21.1	33.2	36.4	42.6	36.7	36.7	39.5	46.3	40.8
	Non-Maori Female	Crude	4.1	3.3	4.0	5.6	6.4	5.1	5.9	8.5	6.6
	Maori Male	Crude	24.8	27.9	35.3	42.4	38.4	38.3	43.9	44.2	43.0
	Non-Maori Male	Crude	6.3	6.6	7.0	9.3	12.8	13.7	14.5	16.3	18.0
	Maori Total	Crude	22.9	30.6	35.9	42.5	37.6	37.5	41.7	45.3	41.9
	Non-Maori Total	Crude	5.2	4.9	5.5	7.4	9.5	9.3	10.1	12.3	12.2
	Maori Female	ASR**	21.1	33.2	36.4	42.6	36.7	36.7	39.5	46.3	40.8
	Non-Maori Female	ASR**	5.5	4.5	5.5	7.6	8.4	6.5	7.5	10.8	8.3
	Maori Male	ASR**	24.8	27.9	35.3	42.4	38.4	38.3	43.9	44.2	43.0
	Non-Maori Male	ASR**	6.9	6.9	7.7	10.4	14.0	14.5	15.0	16.2	18.4
	Maori Total	ASR**	22.9	30.6	35.9	42.5	37.6	37.5	41.7	45.3	41.9
	Non-Maori Total	ASR**	6.2	5.7	6.6	9.0	11.2	10.4	11.2	13.5	13.3

Notes:
Sexual Health Clinic (SHC) data only
Number of SHCs participating from year to year may vary
*Only confirmed cases are included for chlamydia and gonorrhoea
** Age standardised rates, standardised to the Maori population
Population denominators used were June 30 population estimates for 1997 to 2005 from Statistics NZ

Additionally, the quarterly ESR Sexual Health Clinic Surveillance of STIs in New Zealand for 2006 reveal that Maori have higher rates of infection of gonorrhea and chlamydia than European/Pakeha and Pacific peoples.

In relation to the rates of abortion in New Zealand, there has been a consistent decrease over the past three years. Although the number of induced abortions has dropped over the years (18,510 in 2003 and 18,210 in 2004), the rate for the year ended 2005 is 17,530 which is still comparatively high to other western developed countries but comparable to the rates in Australia,

14 Special request for ethnicity data from ESR, July 2006. The crude and age standardised rates for Maori and non-Maori have been calculated seperately by sex and overall. Population estimates were used for each year from Statistics NZ and standardised to the Maori population.

Sweden and the USA.[15] In 2005 Maori accounted for 3,880 abortions, which was the second highest rate in the country. Europeans accounted for 9,730 abortions, and both Asian and Pacific peoples had abortions rates of under 3,000 each.[16]
Concerning also are the statistics for new HIV diagnoses in New Zealand. Although rangatahi do not appear as significantly in the statistics as adults, there are a variety of people being newly diagnosed with HIV each year, including men who have sex with men, people heterosexually infected, children infected through mother to child transmission, and people infected in other ways, such as infection among injecting drug users. In 2005, 183 people were newly diagnosed with HIV through antibody testing, which is a 17% rise from 2004. In 2005, 89 MSM (men who have sex with men) were diagnosed with HIV through antibody testing. This is a 19% increase from figures in 2004, which is continuing the trend of significant increases in HIV diagnosis among MSM since 2003. Of these 89 MSM, infection was reported for 66 (74%) of those diagnosed in 2005. "The average age of these 66 men was 37 years, with most - 27 (41%) - in the 30-39 year age group. Nevertheless there was a wide range with 23% aged less than 30 years old, and 15% aged 50 years or more…Most of these men (70%) were of European ethnicity, with 14%, 9% and 5% being of Maori, Asian and Pacific ethnicity respectively."[17]

There were also 73 HIV diagnoses among people heterosexually infected, which is a similar figure to 2004. Six infants were diagnosed with HIV in 2005 from mother to child transmission; 4 being born in New Zealand and 2 overseas. "None of the mothers of the affected children had had their HIV diagnosed prior to giving birth…Since 1995, there have been no cases in New Zealand where a mother with HIV diagnosed prior to giving birth has had an infected baby."[18]

Another potential area of concern with regard to the sexual and reproductive health of rangatahi is related to the sex industry. Although there appear to be no statistics on the ethnic make up of sex workers, we know anecdotally that some rangatahi are turning to prostitution as a way of surviving. In relation to underage commercial sexual activity, three New Zealand studies have identified the incidence of child prostitution. Dr Miriam Saphira in her 2004 study entitled, "The Involvement of Children in Commercial Sexual Activity," surveyed 47 respondents aged between 15 and 47 years old.[19] She found that on average, respondents first received payment for sex at 14.5 years old. Similarly, Plumridge and Abel (2001) found that of the 303 female sex workers surveyed, 31% said they had begun sex work prior to turning eighteen.[20] In the 2005 repor, "The Nature and Extent of the Sex Industry in New Zealand: an Estimation" prepared by the Prostitution Law Review Committee, it is estimated that approximately 3.5% (210 individuals) of the total number of sex workers in New Zealand (working on the street, or for an escort agency or privately), are under eighteen years old.[21]

It is, however, difficult to provide an overview of Maori sexual and reproductive health statistics. There are a number of reasons for this, including the inability of the current health (and other) monitoring systems to obtain complete data, to identify ethnicity accurately and the under-reporting of Maori health statistics in general.[22] Therefore the statistics we do have do not give a true picture of how STI's and other sexual and reproductive health matters fully impact on Maori.

It is possible though to get an overview picture of the disparities in sexual and reproductive health, as well as the scope of the type of disparities, by piecing together statistics from different sources.

In a recent tender for policy advice on sexual and reproductive health by the Ministry of Health, the current incidence of sexually transmitted infections was summarised.

> "Current data show that overall rates for chlamydia, gonorrhoea and genital warts are highest in the 15–19 years age group. Rangatahi Maori appear to have higher rates of STIs than Pakeha, especially for chlamydia and gonorrhoea, both of which can have long-term impacts on health, such as ectopic pregnancy and infertility.
> Groups at higher risk, by STI, are:
> - chlamydia: Maori and Pacific peoples, young people aged under 25
> - gonorrhoea: Maori and Pacific peoples, males aged under 20

15 In 2004, the general abortion rate (abortions per 1,000 women aged 15–44 years) for New Zealand was 20.5 per 1,000. Germany (7.7), Scotland (11.8), Denmark (14.4), Norway (15.3), and England and Wales (16.9) had lower rates. In Australia (19.7 in 2003), Sweden (20.0) and the United States (20.9 in 2002), the abortion rate was similar to the New Zealand level.

16 Statistics New Zealand website, visited on 13 December 2006:

http://www.stats.govt.nz/products-and-services/hot-off-the-press/abortion-statistics/abortions-ye-dec05-hotp.htm?page=para002Master

17 AIDS New Zealand, Issue 57 – February 2006, Ministry of Health website, Viewed on 18 December 2006.

http://www.moh.govt.nz/moh.nsf/238fd5fb4fd051844c256669006aed57/ed0c1c41deeb681dcc257145007a9021?OpenDocument.

18 ibid.

19 Saphira, Miriam. (February 2004). The Involvement of Children in Commercial Sexual Activity, www.ecpat.org.nz.

20 Plumridge, L., & Abel, G. (2001). A 'segmented' sexual industry in New Zealand: sexual and personal safety of female sex workers, Australian and New Zealand Journal of Public Health.

21 Ministry of Justice. The Nature and Extent of the Sex Industry in New Zealand: An estimation. (April 2005). Wellington: Ministry of Justice.

22 This fact was also raised by submitters at the recent Parliamentarians Forum on Population and Development held in Wellington on 4 December 2006.

- genital herpes: Maori and Europeans, all age-groups
- genital warts: all ethnic groups, young people aged under 25."[23]

In a recent speech to the New Zealand Family Planning Association in Christchurch and in a speech on 'Gender Equality in the Pacific Region' delivered in Parliament, the Women's Affairs Minister, Lianne Dalziel, spoke of the significant, and possible devastating, impact of chlamydia on young Maori.

> "New Zealand's rate of teenage pregnancy is similar to the level 20 years ago, but it is high in comparison to other OECD countries, and it appears, from the limited data we have, that the chlamydia rate is also one of the highest in the developed world; six times higher than that of Australia, four times higher than that of the UK. This silent disease has no symptoms in around 70% of those infected; but if left untreated it can impact on the fertility of both women and men."

There are a number of other factors that impact on sexual and reproductive health for Maori, including the mismatch between what young people report they know and the statistics on STI's and teenage pregnancy; the complexities of sexual behaviour and the protective mechanisms that are used by youth; and the viewing of teenage pregnancy as a problem.

Jackson (2004) acknowledges in her article, "Identifying Future Research Needs for the Promotion of Young People's Sexual Health in New Zealand," that we really don't know why youth have high rates of STIs and high rates of pregnancy.

> "The literature reviewed in this paper indicates that in some aspects of sexual and reproductive health we have very clear data, although it is weighted toward European, middle-class samples. However, substantially less clear are the explanations for the gap between what young people report they know about sex, STIs, pregnancy and safer sex, and the statistics that tell us that the 15-19-year-old age group show high rates of STIs and high rates of pregnancy."[24]

In fact, Nash (2001) concurs with Jackson and believes, "There is an urgent need for further research into the social conditions that give New Zealand one of the highest teenage pregnancy rates in the world."[25] Even with a recent, apparently successful, Ministry of Health safe sex campaign, it is unknown what impact the campaign will have on youth behaviour.

> "The No Rubba, No Hubba Hubba campaign which ran from September 2004 to June 2005, was specifically targeted at reducing STIs in 15-19 year olds with a particular emphasis on reaching Maori rangatahi and Pacific youth. An evaluation of the campaign has demonstrated raised awareness in Maori, Pacific and European youth of safer sex issues as a result of the campaign, and a reduction in the proportion who say they would have sex without a condom…however, whether the campaign will result in changed behaviours is not yet known and STI rates remained high during 2005 for 15-19 year olds."[26]

In her 1998 Masters thesis, "Safer Sex? Young Maori Women's Experience of Sex, Coercion and Contraceptive Use,"[27] Tania Pouwhare highlights some of the complexities experienced by young Maori women. In interviews with nine Maori women aged between 16 and 20, Tania Pouwhare found complex motivations for not using contraception. Most significant was the finding that young Maori women were not confident, not in control, and often were in relationships where communication was poor. More specifically, young Maori women gathered inaccurate information from friends and the media about contraceptive information. Additionally, all of the women interviewed had experienced unwanted sex. There was little control over whether sex was practiced safely, including when sex occurred, because of feelings of guilt, the perceived loss of their partner, or the potential of a violent response from their partner. Alcohol was another factor involved, where alcohol was used as a coping mechanism after experiencing unwanted sex and also that alcohol limited safe sex and contraceptive practices.

In an Adolescent Health Research Group study by Clark, Robinson, Crengle, & Watson (2006), "Contraceptive use by Maori youth in New Zealand: associated risk and protective factors," data was utilised from the Youth2000 survey, a 2001 anonymous nationally representative secondary school health and wellbeing survey. Half the Maori students (54% males, 48%

23 Ministry of Health tender for policy advice paper, June 2006.

24 Sue Jackson (2004). "Identifying Future Research Needs for the Promotion of Young People's Sexual Health in New Zealand." Social Policy Journal of New Zealand, Issue 21, March 2004.

25 Roy Nash, (2001). "Teenage Pregnancy: Barriers to an integrated model for policy research." Social Policy Journal of New Zealand, Issue 17, December 2001. (200-213). Page 210.

26 "Sexually Transmitted Infections in New Zealand: Annual Surveillance Report 2005" Prepared as part of a Ministry of Health Contract for scientific services by STI Surveillance Team, Population and Environmental Health Group, Institute of Environmental Science and Research Limited, April 2006, page 31.

27 Pouwhare, Tania, (1998). 'Safer Sex? Young Maori Women's Experience of Sex, Coercion and Contraceptive Use,' MA, Auckland University.

females) reported having had sexual intercourse and a third (33% male, 34% female) were currently sexually active. Most Maori youth who have ever had sex use condoms for contraception (82%) and most youth who were sexually active were consistent users of contraception (71% males, 70% females).[28]

The authors concluded that, "Consistent use of condoms is a common self-reported contraceptive practice by many young Maori. However this behaviour is not universal, and in view of the significant sexual and reproductive health disparities that exist for Maori youth, sexual and reproductive health programmes should examine a broader strategy of promoting protective factors such as strengthening youth-parent relationships and reducing risk factors, such as minimising substance misuse. Together with existing efforts in education, whanau, and community based programmes, these strategies may support healthier sexual health outcomes for Maori youth."[29]

A similar youth survey was conducted by the Adolescent Health Research Group (2003) to determine a health profile of youth who attend secondary school. A total of 9699 students from 114 schools participated in the survey from New Zealand secondary schools across the country. A key conclusion from the survey was that "Students report a high prevalence of positive connections with family and school; these connections are known sources of resiliency in the lives of young people."[30]

Protective factors that influence Rangatahi sexual behaviour were also highlighted in a recent Masters thesis profiling the sexual health behaviours and associated protective factors in young Maori attending alternative education facilities (Clark, 2002).

> "Young Maori self-report significant sexual and reproductive health needs, and engage in multiple health risk taking behaviours. Despite the negative social environments that young Maori in alternative education endure, many have demonstrated resilience in negotiating responsible sexual behaviours. Protective factors identified for young Maori attending alternative education include culture, whanau, school, teachers, peers and spirituality."[31]

Another issue coming up in the research on sexual and reproductive health is a counterargument to the popular belief that teenage pregnancy is a problem. In the speech that Tariana Turia presented at the First National Maori Sexual and Reproductive Health Conference held in Wellington on 1 November 2004, she discusses the problematisation of teenage pregnancy.

> "I am intolerant of the excessive focus on controlling our fertility. When I used to sit around the Cabinet table with colleagues, one of the many hot topics I got into strife about was discussion around the 'problem' of teenage pregnancy. My objection was to the problematisation of conception. Professor Sidney Hirini Mead has discussed how our cosmological beginning as a people, are mirrored in the processes of conception. From the kâkano (seed) develops the koi ora hou (a new life), which - while within the whare tangata (womb) - possesses mauri, whakapapa, wairua, hau and pûmanawa (natural talents). It is then born into the world of light. So when Cabinet Ministers sat around tut-tutting the fact that the fertility rate for Maori females aged 13-17 years was 26.2 per 1000, more than five times that of non-Maori, (4.9% per 1000), I objected to their analysis of our fertility as a problem. If there was respect for our existence as based on kaupapa, the foundation principles of the Maori world, these Ministers may have thought more carefully about the interventions they were seeking to impose. Indeed, their guidance might have been sourced in these words: Ma ratau anake ratau e korero, Ma tatau anake tatau e korero, ehara ma tetahi ake (We will be our own assessors, they in turn will be theirs, it is not for others to judge)."

This view is shared by Barbara Collins (2004) in the research she conducted investigating how young women view and experience teenage pregnancy. Collins conducted interviews with 18 teenage mothers, focus group discussions with 35 young women who were not mothers, and seven interviews with adult women service providers. Although there is a popular view that teenage mothers regret, or should regret, becoming pregnant, Collins found that many benefited from having a child.

> "One of the most common ways young women confirmed the benefits of early motherhood was to describe how having a baby had saved them from worse experiences. Public views portray teenage motherhood as a negative event with

28 Terryann Clark, Elizabeth Robinson, Sue Crengle, Peter Watson (2006). "Contraceptive use by Maori youth in New Zealand: associated risk and protective factors." New Zealand Medical Journal. 27 January, 2006. Vol 119, No 1228.

29 Ibid.

30 Adolescent Health Research Group (2003). "A health profile of New Zealand youth who attend secondary school." Journal of the New Zealand Medical Association, 4 April 2003, Vol. 116, No. 1171.

31 Terryann Clark (2002). Young Maori attending alternative education: A profile of sexual health behaviours and associated protective factors. Unpublished Masters Thesis. The University of Auckland. Page 106.

> severe impacts on many aspects of adolescent and lifelong development, but this fails to acknowledge that…before pregnancy many engaged in risky behaviours or were in risky environments."[32]

Similarly, Clark (2002) notes the importance of the adolescence phase of life and the health impacts for the future, noting that policy needs to shift away from a problematisation focus.

> "Behaviour formed in adolescence has lasting implications throughout the life span, and public health strategies seeking to intervene during this developmental stage must incorporate developmentally and culturally relevant strategies. To date health policy emphasis in New Zealand has focused on prevention of problems, e.g. teen pregnancy. Shifting goals from problem prevention to capacity building requires dramatic shifts in strategies. Focusing exclusively, on prevention strategies singles out high-risk groups thereby dividing young people and reinforcing stereotypes (WHO 1999)."[33]

A similar call for change has come from Nash (2001) who critically looks at New Zealand's current policy making system where, "Social research is increasingly dominated by the concerns of policy makers who define the problem and invite bids from those prepared to supply the desired outcomes."[34] In fact, Nash is critical on a number of points, including: the inappropriateness of using overseas research as a guide to our own policy development; the importance of investigating specific ethnic and social class 'micro-cultures' that result from structural conditions; developing a broader lens of analyses, 'a realist social science framework,' that accounts for the complexity within society; and the need to provide support to expert provider agencies in implementing their interventions and developments in sexual and reproductive health that are appropriate for youth.

Takataapui Research

Takataapui is an inclusive term that incorporates all sexualities; gay, lesbian, bisexual, transsexual, transgender, and intersexual. Sometimes derivatives of the term takataapui differentiate sexualities, such as takataapui wahine for lesbians and takataapui tane for gay men. Within the community there are also a variety of other terms that are used, including 'tane moea tane' for men who have sex with men (MSM). Takataapui literature[35] has been flourishing particularly over the past 10 years, with writing in a variety of areas, including sexuality and identity, HIV/AIDS, takataapui whanau, and takataapui fiction.

Although the term takataapui has historical significance[36] in the Maori vocabulary it has only taken on political clout since the 1990's. However, Lee believes the term was revived and has been present since the 1970's. "Since the seventies, the term takataapui (an intimate companion of the same sex) has been claimed by some Maori activists in celebration of gay sexuality. A version of takataapui is now standard Maori for homosexual." (1992: 76)

Takataapui tane Maori is defined by Herewini and Sheridan (1994: 4) in a Public Health Commission report entitled, *A report on the health needs of Maori gay men*, as "Maori males who identify as gay, bisexual or transgender, or who have sex with other males, or who by orientation are physically attracted to other males. It is therefore broader in scope than the phrase Maori gay men but clearly includes the latter" (as cited in Aspin, S., C. (2000: 27). Trans-Tasman migration and Maori in the time of AIDS. Unpublished PhD Thesis, University of Otago, Dunedin, New Zealand).[37]

In the New Zealand Aids Foundation study called Male Call/Waea mai Tane Ma conducted in 1996 by Aspin et al, the researchers surveyed the use of preferred terms of identity used by Maori men who have sex with men (gay, homosexual, bisexual, takataapui, straight, transgender/transvestite, other), amongst other variables such as sexual behavior, knowledge of AIDS/HIV, and safe sex practice. Report Three: Maori Men Who Have Sex With Men/ Tane Maori Moea Tane (Aspin et al., 1998) found that Maori men on average chose more than one identifying term. 31.1% of Maori respondents chose the term takataapui, and also were significantly more likely to have a strong connection to the gay community than other Maori MSM. Additionally, usage of the term was dependent on whether the person lived rurally or in an urban centre. 36.7% of Maori MSM

32 Barbara Collins, 25 – 26 November 2004. Social Policy, Research and Evaluation Conference Presentation, Wellington. "If I didn't have my baby, I don't know where I'd be: Teenagers as mothers." From Ministry of Social Development website, visited 18 October 2006.

33 Terryann Clark (2002). Young Maori attending alternative education: A profile of sexual health behaviours and associated protective factors. Unpublished Masters Thesis. The University of Auckland. Page 104.

34 Roy Nash, (2001). "Teenage Pregnancy: Barriers to an integrated model for policy research." Social Policy Journal of New Zealand, Issue 17, December 2001. (200-213). Page 210.

35 There has also been a very strong European/Pakeha GLBT voice in New Zealand. This breif section is only concerned with Maori writers and researchers in the area of takataapui literature and research.

36 One of the old Maori stories that exist tell of the close companionship of two male friends who were considered takataapui, or an intimate companion of the same sex.

37 David Murray (2003; 2004) has also written about the historical and contemporary use of the term Takataapui, providing a socio-lingual etymology and socio-political analysis.

who were resident in Auckland, and 30.2% resident in other main urban centres, identified themselves as takataapui as compared to 16% of those living outside urban centres.

As the term takataapui has been gaining legitimacy within the Maori men who have sex with men community, there has also been a corresponding visibility of takataapui as a priority population group within health statistics. More than twenty years into the HIV/AIDS epidemic, there are disturbing new increases in HIV diagnoses in some developed countries, including New Zealand. In 2003 New Zealand saw for the first time ever in the recording of HIV/AIDS data, a significant proportion of HIV diagnoses were reported among Maori males (17%). This information, combined with knowledge about the under reporting of Maori health data in general, and HIV/AIDS in particular, provides considerable cause for concern with regard to the HIV risk of Maori males.[38] This has also resulted in an increase in research projects that are being conducted by Maori health researchers into the impact of HIV/AIDS on Maori. However, research is not limited to HIV/AIDS and includes research in a number of areas, such as: sexuality and sexual and reproductive health (Pihama et al, 2006; Smith and Reynolds, 2006); takataapui tane identity and wellbeing (Aspin et al, 1998; Aspin and Reynolds, 2006); HIV/AIDS and nonconsensual sex (Aspin, 2000; Aspin and Reynolds, 2006; Fenaughty et al, 2006); HIV/AIDS and resiliency (Aspin et al, international project in progress); Mens health (Jones and Aspin, in progress).

A research project that was lead by Reynolds and Aspin (2006) investigated factors that contributed to a reduction in HIV infection by interviewing 20 takataapui tane. The research project focused on the significance of identity from both a cultural and sexual perspective. The research premise was that Maori men who have a strong sense of their identity may be at reduced risk of HIV infection and that this has a beneficial effect on one's health status. The study found that sexual behaviour is complex and identifying as takataapui tane is not necessarily an indicator of reduced risk of transmission of HIV. The term 'takataapui' for Maori men who have sex with men, however, is useful in many ways. A person with a strong cultural base, such as knowing where you come from, and knowing that you are connected to your whanau, hapu and iwi, will have a positive impact on wellbeing. For some Maori men who have sex with men, this strong cultural identification is often a resurgence and reconnection in being Maori. They have often been disconnected from their whanau and communities and are rediscovering their cultural heritage. This finding corresponds with research completed by Te Puni Kokiri, where it was found that, "Whanau, hapu and iwi support systems can enhance identity and self esteem and lessen the likelihood of engaging in risk-taking behaviours. They can also provide access to health promotion messages and health care services." Te Puni Kokiri (1994: 17)

In another research project (Aspin and Reynolds, 2006) with Maori men who have sex with men, serious concerns were raised about the HIV risk of men who have non-consensual sex with other men. The risk of HIV transmission is significant in non-consensual sex because a condom is often not used. In the interviews of eight Maori MSM men who have had experiences of non-consensual sex, there were eleven cases of forced sex reported with eight of these cases involving forced anal penetration or rape by the perpetrator, which included violent assault for some. Condoms were not used in any of these cases. The men also reported serious health impacts such as long-term anxiety, compulsive disorders and social isolation. The lack of an appropriate social support service was a major issue for all participants.

As may be self-evident from the above list of takataapui research projects, there is a dearth of research outside of that conducted on takataapui tane health and wellbeing. Pihama (1998) addresses this concern directly in relation to lesbian whanau.

> "Given the dearth of material written about lesbian women in this country there is little information to draw upon. Miriam Saphira's research in the 1980s was an initial attempt to position lesbian mothers positively in a generally negative environment of representation. However, even within this ground-breaking research there is little acknowledgement or discussion given to the cultural ways in which whanau or families are constituted. For Maori lesbian women there exist cultural possibilities that enable us to explore wider options in parenting and whanau. In order to ensure wide access to these options we need to participate in active reclaiming and affirmation of whangai, whanau and whakapapa as cultural tenets.

38 This fact that Maori may be at greater risk from HIV/AIDS than non-Maori, related in part to the under reporting of AIDS/HIV notifications, was identified in the 1994 Te Puni Kokiri report about HIV/AIDS and Maori. Te Puni Kokiri (1994). Mate Ketoketo/Arai Kore. A report about HIV/AIDS and Maori. Wellington: Te Puni Kokiri.

> For lesbian women who have chosen to have children, whether it be through whangai, fertility clinic processes, donor self-insemination or from heterosexual relationships there is a potential to challenge those dominant discourses about 'family' and 'marriage' that have served to oppress Indigenous Peoples, women, lesbians and gays."[39]

In relation to the changing construction of whanau, several Maori-led research projects have written in this area, including Glover (2006) in relation to Maori infertility and a new project led by Reynolds et al on Maori Views and Experiences of Fertility, Reproduction and Assisted Reproductive Technologies.[40] The aim of the project by Reynolds et al is to gather information on the diverse ways in which Maori have (past and present) engaged with Assisted Reproductive Technologies. The project seeks to develop a database of Maori narratives and moteatea as a means of understanding traditional notions related to fertility and reproduction, provide information on how fertility may be conceptualised for whanau, and provide health providers with an understanding of Maori views in the area of fertility.

The number of takataapui authors writing about their own experiences and stories or writing in the area of Maori fiction has also grown over time. This genre of writing includes: autobiographies by Georgina Beyers, and Carmen; Mana wahine writing by Ngahuia Te Awekotuku; Maori fiction writing by Witi Ihimaera; and a new compilation of takataapui stories published by Huia Publishers in 2007, to mention but a few.

Policy

Introduction

This section provides an overall scoping of where sexual and reproductive health service and policy fits within various ministries and how sexual and reproductive health service provision is implemented.

The area of sexual and reproductive health is limited in scope largely because of how it is defined in government policy and regulation, which also has direct implications for service provision. The current focus and thus priority areas for funding include youth, unwanted pregnancies and sexually transmitted diseases, which includes the prevalence of HIV/AIDS. The priority on youth in government policy for example, does not address the fact that a number of studies indicate that adults are fast becoming the most vulnerable group affected by sexual and reproductive health issues, especially in relation to HIV/AIDS.

The principal ministry responsible for sexual and reproductive health policy and service provision is the Ministry of Health. However, different aspects of sexual and reproductive health policy and service provision are spread across different ministries and government organisations. The fragmentation of policy and service provision across different government organisations results in an approach that is uncoordinated and piecemeal.

The area of sexual and reproductive health is also impacted by a number of issues, illustrative of the complexity of the area. Although this is not an exhaustive list, issues within sexual and reproductive health include a wide variety of areas:

Health and wellbeing
Socio-economic status and impacts on Maori health
Politics – disparities in health & under-reporting of health statistics
Whanau/family – complexity of contemporary whanau
Tamariki, Rangatahi, Tane/Wahine, Kuia/Koroua health
Adoption/whangai
Sex
Prostitution – child prostitution
Sex education – contraception & safe sex
Religion and sexual and reproductive health – morality, values, beliefs
STI's and infectious diseases
HIV/AIDS
Fertility/Infertility
Pregnancy & birth

39 Pihama, L. (1998). "Reconstructing Meanings of Family: Lesbian/Whanau and Families in Aotearoa." In "Families in New Zealand," edited by Vivienne Adair and Robyn Dixon. Auckland, Longman Publishing.

40 "He Kakano: Maori Views and Experiences of Fertility, Reproduction and ART" Reynolds et al. Awaiting HRC funding decision.

Reproduction and reproductive systems
Human assisted reproductive technologies
Abortion
Violence and sexual abuse – non-consensual sex, rape, sexual abuse, incest
Gender
Women's health
Men's health
Sexuality & sexuality theory
Sexual orientation & identity – homosexual, heterosexual, transsexual, transvestite, bisexual, lesbian, gay, Takataapui, intersex.
Eugenics – the state control of human sexual and reproductive behaviour
Cancer – cervical, testicular
Health risk factors and behaviour - tobacco, alcohol, drugs, etc.

It is therefore not surprising that sexual and reproductive health issues have an impact in a variety of government ministries and organisations. What follows are two sections that will provide an overview of definitions (and associated terminology) guiding the scope of sexual and reproductive health in New Zealand, and also New Zealand Government policy and sexual and reproductive health.

Definitions (And Associated Terminology) Guiding The Scope Of Sexual And Reproductive Health In New Zealand

Definitions of sexual and reproductive health have an international context. Most significant to how New Zealand defines sexual and reproductive health was the 1994 United Nations' International Conference on Population and Development (ICPD) held in Cairo. New Zealand was one of the 179 signatory countries to the ICPD Programme of Action (1995 – 2015). Additionally, the World Health Organisation (WHO) is an authority on health for the western world in particular, as well as monitor and guardian of Third World health. New Zealand is guided by the provisions of WHO and in particular in following the intention of the 1986 Ottawa Charter. It is therefore necessary to refer to internationally recognised definitions of health terminology as this defines public health policy in New Zealand.

The 1994 United Nations' International Conference on Population and Development (ICPD) Programme of Action defines reproductive health and sexual health in the following way.

> "**Reproductive health** is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. It also includes sexual health, the purpose of which is the enhancement of life and personal sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."[41]

> "**Sexual health** is women's and men's ability to enjoy and express their sexuality, and to do so free from risk of sexually transmitted diseases, unwanted pregnancy, coercion, violence and discrimination. Sexual health also means being able to have an informed, enjoyable and safe sex life, based on self-esteem, a positive approach to human sexuality, and mutual respect in sexual relations. Sexual health enhances life, personal relations and the expression of one's sexual identity. It is positively enriching, includes pleasure, and enhances self-determination, communication and relationships."[42]

The Department of Reproductive Health and Research (RHR),[43] a department within the World Health Organisation, defines the area of sexual and reproductive health in parts by providing: a broad definition of sexual health; working definitions of sex, sexuality, sexual health, and sexual rights; and a definition of reproductive health as part of a WHO strategy initiated in 2004, "Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets."

41 Programme of Action of the UNICPD, 1994.

42 Ibid.

43 Department of Reproductive Health and Research (RHR), World Health Organisation,
http://www.who.int/reproductive-health/gender/sexual_health.html#3
Visited: 19 June 2006.

"**Sexual health** is influenced by a complex web of factors ranging from sexual behaviour and attitudes and societal factors, to biological risk and genetic predisposition. It encompasses the problems of HIV and STIs/RTIs, unintended pregnancy and abortion, infertility and cancer resulting from STIs, and sexual dysfunction. Sexual health can also be influenced by mental health, acute and chronic illnesses, and violence. Addressing sexual health at the individual, family, community or health system level requires integrated interventions by trained health providers and a functioning referral system. It also requires a legal, policy and regulatory environment where the sexual rights of all people are upheld. Addressing sexual health also requires understanding and appreciation of sexuality, gender roles and power in designing and providing services. Understanding sexuality and its impact on practices, partners, reproduction and pleasure presents a number of challenges as well as opportunities for improving sexual and reproductive health care services and interventions."[44]

Working definitions from the WHO website include:
"**Sex** refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females. In general use in many languages, the term sex is often used to mean "sexual activity", but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred."[45]

"**Sexuality** is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors."[46]

"**Sexual health** is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."[47]

"**Sexual rights** embrace human rights that are already recognised in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:
the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
seek, receive and impart information related to sexuality;
sexuality education;
respect for bodily integrity;
choose their partner;
decide to be sexually active or not;
consensual sexual relations;
consensual marriage;
decide whether or not, and when, to have children; and
pursue a satisfying, safe and pleasurable sexual life.
The responsible exercise of human rights requires that all persons respect the rights of others."[48]

A definition of reproductive health, which was adopted at the United Nations Programme of Action of the International Conference on Population and Development in New York in 1994 (ICPD), is used in the brochure produced as part of a WHO strategy initiated in 2004, "Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets."[49]

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44 Ibid.

45 ibid.

46 ibid.

47 ibid.

48 ibid.

49 WHO website, accessed on 26 June 2006, http://www.who.int/reproductive-health/strategy.htm

> "**Reproductive health** is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, **reproductive health care** is defined as the constellation of methods, techniques and services that contribute to reproductive health and wellbeing by preventing and solving reproductive health problems. It also includes **sexual health**, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases." (Paragraph 7.2) "Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. ..." (Paragraph 7.3)[50]

In a more specific New Zealand context, rangatahi sexual wellbeing is defined in the 1997 Ministry of Health publication, "Rangatahi Sexual Wellbeing and Reproductive Health: The Public Health Issues," as "…being an outcome of all of the complex social, economic, cultural and political influences within which rangatahi will determine their sexual orientation and develop their sexual identity and expression. Rangatahi will work towards this outcome by making informed choices about celibacy or abstinence options, or establishing and maintaining safe and responsible relationships to enhance their own and their partner's (or partners') sexual wellbeing."[51]

Rangatahi reproductive health is defined as "…the ability of rangatahi to determine if, when, and how often they will exercise their physical and emotional capacity to conceive, and carry a pregnancy through to positive, healthy results for mother and baby within their whanau. They will achieve this by accessing safe, culturally effective, acceptable and affordable family planning and / or childbearing services."[52]

New Zealand Government Policy And Sexual And Reproductive Health

Maori, Government Policy And Sexual And Reproductive Health

The New Zealand Government accepts a clear responsibility for unimpeded access to, and equitable provision of, health services for Maori. Reducing inequalities in health care is a key goal of the Ministry of Health and the New Zealand Government. However, it is internationally recognised that Indigenous Peoples must have self-determination over the resources and provision of health services to Indigenous Peoples. The World Health Organisation's (WHO) often-cited 1986 Ottawa Charter, sees empowerment of communities through the ownership and control of their own endeavours and destinies as a major component of health provision and promotion. This issue of self-determination and where Te Tiriti o Waitangi lies in regards to Article II rights is still being contested by hapu and iwi.

The New Zealand Government provides resourcing for over 200 Maori health providers throughout the country. In the 2003 Ministry of Health publication, "Sexual and reproductive health - A resource book for New Zealand health care organisations," it states, "The Government is committed to reducing health inequalities. It has a particular responsibility to Maori – as Treaty of Waitangi partners and citizens. This means tackling the wider issues that impact on health. It means actively promoting whanau wellbeing through quality education, suitable housing and employment opportunities. It means putting into practice the Treaty principles of partnership, participation and protection."[53]

WHO brochure (2004). "Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets," World Health Organisation, Geneva Department of Reproductive Health and Research including UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction.

50 Ibid.

51 Ministry of Health (1997). "Rangatahi Sexual Wellbeing and Reproductive Health: The Public Health Issues." Page 5.

52 Ibid.

53 Ministry of Health (2003). "Sexual and reproductive health - A resource book for New Zealand health care organisations." Page 29.

However, the ability to provide specific kaupapa Maori health provision is limited not only because of the inadequate resourcing but also because Maori are not deciding what provision is necessary for their communities. In a report outlining the economic determinants of Maori health and disparities prepared by Bridget Robson, she elaborates on this point.

> "There is a strong driving force among Mäori for economic, educational, social, cultural and health development. 'By Mäori for Mäori' providers in education, health and social services are growing in number and size. Many are providing services for all New Zealanders. Mäori owned and operated businesses are increasing and demand for education is flourishing as Mäori-controlled education institutions provide effective learning environments for all age-groups. Whänau, hapu, iwi and other Mäori collectives are building strategies for positive long-term development.
> However, Mäori-led services still only receive a tiny fraction of the funding available, limiting the access of many Mäori to such services and perpetuating structural inequalities by forcing Mäori initiatives to operate on inadequate funding. At the same time, the existence of educational, occupational and wage discrimination is forming powerful, restraining forces restricting not only Mäori access to health and social benefits available to non-Mäori, but also limiting Mäori from maximising the opportunities provided by Mäori initiatives."[54]

As is recognised in Indigenous scholarly research, Indigenous people do not have the same needs as non-Indigenous people and require targeted and specific health provision needs and interventions. Therefore, the models and methods used in mainstream sexual and reproductive health service provision do not work for us. As Dr Karina Walters stated in a recent community workshop presentation, "We can't import Western models (of say sexual education) to be used with our own people. We need to go back to our own traditions."[55]

In a kaupapa Maori worldview sexual health and reproductive health is part of a wider context. That includes whakapapa, the tapu of a person, includes appropriate relationships and is connected to hauora generally. This report further elaborates on Maori worldviews in Part Four.

In relation to sexual and reproductive health and Maori, service provision is determined by Government through advice given primarily by the Ministry of Health, but also through other ministries and agencies such as the Ministry of Education, Ministry of Social Development, Ministry of Youth Development, Ministry of Justice, Te Puni Kokiri and Ministry of Women's Affairs.

Sexual And Reproductive Health Within Government Ministries

As an overview of where Maori sexual and reproductive health sits in the different ministries, it is useful to present some of the policy documents and reports that influence sexual and reproductive health service provision within each Ministry.

1. Ministry Of Health

The Ministry of Health is responsible for developing and maintaining an effective public health sector including providing policy and strategic advice and managing public health issues and services for sexual and reproductive health. However, in the Ministry of Health Statement of Intent 2006 – 2009, the specific area of sexual and reproductive health does not appear as a significant health priority.

THE BASIC STRUCTURE OF THE MINISTRY OF HEALTH:

1. Minister of Health (Advisory Committees report to the Minister, for example the Advisory Committee on Assisted Reproductive Technology)
2. Ministry of Health - Directorates: Clinical Services, Corporate and Information, DHB Funding and Performance, Maori Health, Disability Services, Mental Health, Public Health, Sector Policy.
3. District Health Boards (21)
4. Primary Health Organisations (81) and other service providers.

54 Economic determinants of Mäori health and disparities: A review for Te Röpü Tohutohu i te Hauora Tümatanui (Public Health Advisory Committee of the National Health Committee), Bridget Robson, Te Röpü Rangahau Hauora a Eru Pömare, Wellington School of Medicine and Health Sciences, University of Otago, June 2004, Page 42.

55 Community workshop held in Whanganui in June 2006 as part of the lead up to the bi-annual Nga Pae o te Maramatanga conference held at Te Papa, Wellington. Dr Karina Walters from the Choctaw Nation in the USA was keynote speaker.

Within this structure also are Maori Health Providers who may be contracted directly with the Ministry or through District Health Boards. At present there are 240 Maori Health Providers who are contracted to 21 District Health Boards.[56] Sexual and reproductive health service providers are contracted directly with the Ministry and others are contracted through District Health Boards.

Within the Ministry of Health organisational structure, sexual and reproductive health is administered in different areas. The Public Health Directorate funds contracts for PHO's and other service providers. The Ministry of Health funds District Health Boards, who provide funding for sexual and reproductive health contracts to DHB service providers. The Ministry also has a small unit focusing on sexual and reproductive health, concentrating on providing policy advice to the Minister and managing sexual and reproductive health campaigns and contracts.

The Ministry has also established a dedicated website to sexual and reproductive health (www.moh.govt.nz/sexualhealth). The site provides access to the following: Ministry of Health Information (including the Sexual and Reproductive Health Strategy), Youth Sexual Health Campaign 2004/05, The Hubba Hubba website, health education resources, relevant publications on other sites, and related information.

Linked to the Ministry of Health website is also the Public Health Surveillance website. Public Health Surveillance provides access to a selection of New Zealand public health surveillance information. The Ministry of Health contracts the services of the Institute of Environmental Science and Research Ltd (ESR) to coordinate and report this surveillance information. Surveillance of Sexually Transmitted Infections is one area that is covered in Public Health Surveillance. Data is submitted to ESR monthly from sexual health clinics, family planning and student and youth health clinics, and some laboratories. However, the collection of STI data is incomplete because not all clinics or laboratories are participants, and not all cases are reported through clinic-based or laboratory surveillance systems. The data that is submitted to ESR is also incomplete. Clinics submit anonymised data on age, sex and ethnicity. Laboratories submit anonymised data on confirmed cases of chlamydia and gonorrhoea by age and sex.[57]

Public Health Intelligence (PHI) is also another agency that provides information for the Ministry of Health in order to meet its statutory responsibility in monitoring the state of public health in New Zealand. Public Health Intelligence monitors public health for the Ministry by providing the following services: surveys, health geoinformatics, modelling and forecasting and surveillance.

The Maori Health Directorate has an overall responsibility for Maori health in Aotearoa. They are specifically responsible for providing, "policy advice on the overall strategy for achieving the government's objective for Maori health, which is to reduce inequalities in health status for Maori and improve Maori health and disability status. We will work with other directorates, sections and teams within the Ministry to enable them to increase their understanding and responsiveness to the needs and aspirations of Maori and to equip them in their role to improve Maori health. Our role is also to develop relationships with the key organisations and agencies that contribute to a health and disability sector with a view to improving Maori health and disability status, and facilitating leadership within the Maori health sector."[58]

Key Ministry Documents And Initiatives

In order to map a genealogy of policy influencing sexual and reproductive health service provision, it is important to present a number of key documents and initiatives from the Ministry of Health.

Taskforce On Adolescent Sexuality: 1988

Department of Health. (1990). Adolescent Sexuality: The report of the taskforce on adolescent sexuality. Wellington: Department of Health.

In 1988 the Department of Health established the Taskforce on Adolescent Sexuality to advise the government on the development of a national policy to promote positive adolescent sexuality.

Sexual And Reproductive Health Strategy: May 1996

The overall aim of the strategy is to promote responsible sexual behaviour to minimise unplanned pregnancies, reduce abortion rates and incidence of sexually transmitted diseases and HIV/AIDS.

56 Maori Health Directorate, http://www.moh.govt.nz/moh.nsf/menuma/Maori+health+providers?Open. Visited 16 November 2006.

57 Public Health Surveillance website. http://www.surv.esr.cri.nz/public_health_surveillance/sti_surveillance.php. Visited 2 November 2006.

58 Maori Health Directorate website, visited 30 October 2006. http://www.moh.govt.nz/moh.nsf/pagesma/321

The Sexual and Reproductive Health Strategy objectives are: "reduced rates of abortion; reduced rates of unwanted pregnancy; reduced spread/prevention of STI's including HIV/AIDS; improved access to contraceptive information and products; improved delivery of sexual and reproductive health services to Pacific Island Peoples; delayed onset of sexual activity; updating information about the interrelationships between reproductive and sexual health, education, employment and family life for ongoing policy development; provision of information about sexual and reproductive health challenges for rangatahi to develop evidence-based policy; improved information about delivery of sexual and reproductive health education in schools."[59]

In 1997 the Ministry of Health's Public Health Group published the report, "Rangatahi Sexual Wellbeing and Reproductive Health: The Public Health Issues." This report was developed by the Public Health Group, in consultation with the public, in conjunction with the 1996 report, "A Strategic Direction to improve and protect the public health," and "He Matariki: A Strategic Plan for Maori Health," published in 1995.

SEXUAL AND REPRODUCTIVE HEALTH STRATEGY - PHASE ONE: OCTOBER 2001

The Sexual and Reproductive Health Strategy indicated the overall direction the government wished to take to achieve positive and improved sexual and reproductive health for all New Zealanders. The Ministry of Health established a Sector Reference Group made up of a group of independent experts in the field to help develop the Sexual and Reproductive Health Strategy for New Zealand. Phase one provides the guiding principles and outlines the strategic direction.

In 2002 two other Ministry strategy documents that attempt to reduce the health inequalities that affect Maori, and for setting the direction for Maori health development were published: "He Korowai Oranga: The Maori Health Strategy" and "Whakatataka: Maori Health Action Plan 2002-2005."

SEXUAL AND REPRODUCTIVE HEALTH STRATEGY - PHASE TWO: 2003

1. Sexual and reproductive health - A resource book for New Zealand health care organisations: 2003
2. HIV/AIDS Action Plan: Sexual and Reproductive Health Strategy

In the second phase of the strategy (2003), the Ministry focused on District Health Boards and Primary Health Organisations and the role they play in improving the sexual and reproductive health of their communities.

Phase two involved the development of a population-specific plan for Maori and another document for Pacific peoples, which will guide and relate to specific action plans for the management of STIs, addressing unwanted/ unintended pregnancy and HIV/AIDS.

A plan for sexual abuse and sexual violence will also be developed.

In June 2006 the Ministry of Health called for submissions from interested parties to provide advice and discussion papers on the development of policy and service advice on gathering Maori sexual and reproductive health information, in particular to identify strategies on how best to meet the needs of Maori public health providers working in the area of sexual and reproductive health. The
paper calls for:

- Public policy advice to reduce the inequalities between Maori and non-Maori related to sexual and reproductive health;
- Public advice/response to key issues and/or publications relevant to Maori sexual and reproductive health;
- Contribution toward strengthening the national Maori sexual and reproductive health sector;
- Operation and promotion of an information service on Maori sexual and reproductive health, for community workers, practitioners,
- researchers, and others;
- Facilitating or attending health promotion activities to reduce inequalities;

Report to the Ministry on emergent issues regarding the sexual and reproductive health of Maori.

In October 2006 the New Zealand Parliamentarians Group on Population and Development (NZPPD), a multi-party group of politicians, invited government agencies, non-governmental organisations, and other professionals from youth, health and education services to present oral submissions to an open hearing on youth sexual and reproductive health. The NZPPD sees the open forum, held in Parliament Buildings on 4 December 2006, as an opportunity to raise awareness amongst

59 Ministry of Health website, visited 29 October 2006. http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c2566a40079ae6f/fe8201ab853bfaafcc256c32007fda59?OpenDocument

parliamentarians of the current issues around young people and sexual and reproductive health. Oral submissions will also contribute to a report being prepared for Government, Parliamentarians, public servants and others, as well as inform the upcoming Pacific Parliamentarians Meeting in February 2007 on youth issues.

2. Ministry Of Education

The Ministry of Education is primarily responsible for developing and implementing the New Zealand school curriculum. Within the school curriculum, sexual and reproductive health forms part of the content in the Health and Physical Education Curriculum area.

DEPARTMENT OF EDUCATION (1985). HEALTH EDUCATION IN PRIMARY AND SECONDARY SCHOOLS. WELLINGTON: DEPARTMENT OF EDUCATION.

> "This syllabus contained specific provision for sexual health education beginning at Form 1 Level (Year 7), while supporting the development of knowledge, skills and attitudes to enhance relationships, care for the body and keep safe, at levels below this. The 1985 syllabus replaced one developed in 1945, which contained no provision for the inclusion of group or class instruction in sexual health education at primary school. The development of the 1985 syllabus with its provision for group and class instruction in sexual health education was contentious."[60]

EDUCATION REVIEW OFFICE. (1996). REPRODUCTIVE AND SEXUAL HEALTH EDUCATION: A REPORT PROVIDED BY THE EDUCATION REVIEW OFFICE FOR THE MINISTRY OF HEALTH. WELLINGTON.

The Education Review Office in 1995 conducted a review of sexual and reproductive health education provision by sampling 100 schools from around New Zealand. ERO found that the reproductive and sexual health education that was provided by schools was lacking, with limited information provided to students, unclear selection of resources, and piecemeal programme delivery. The programme was usually delivered by a school staff member in combination with an outside "expert," and few offered clinical support services as a companion to their programmes.

EXPLAINING AND ADDRESSING GENDER DIFFERENCES IN THE NEW ZEALAND COMPULSORY SCHOOL SECTOR: A LITERATURE REVIEW. (1999). WELLINGTON: MINISTRY OF EDUCATION.

This review explored the gender differences in the seven curriculum areas during the period 1989 to 1999. Within the Health and Physical Education Curriculum, of which Sexuality is a part, the review of research revealed that "schools reproduce and communicate messages about the gender appropriateness of physical activity through:

- Pedagogies based on different expectations of male and female students;
- Narrow choices of activities in class/valuing some activities over others;
- Failing to challenge sexist and homophobic language;
- Reinforcing values of aggression and competition at the expense of co-operation and upskilling students;
- Failing to identify and work with the strengths of students - being non-inclusive;
- Separating pedagogies for the body from identity and emotion;
- Failing to recognise how social identity is linked to physical activity."[61]

MINISTRY OF EDUCATION. (1999). HEALTH AND PHYSICAL EDUCATION IN THE NEW ZEALAND CURRICULUM. WELLINGTON: LEARNING MEDIA.

The Health and Physical Education Curriculum sets out the Ministries expectations of achievements for students Year 1 to Year 13. The sexual and reproductive health component of the Health and Physical Education Curriculum sets out expectations of achievement for students in Forms 1 – 7; Year 7 to Year 13.

Sexuality Education is considered one of the seven[62] key areas of learning in the Health and Physical Education Curriculum in New Zealand.

> "In this curriculum, the term "sexuality education" includes relevant aspects of the concept of hauora, the process of health promotion, and the socio-ecological perspective. The term "sex education" generally refers only to the physical dimension of sexuality education. Students will consider how the physical, social, mental and emotional, and spiritual dimensions of sexuality influence their well-being. Through the socio-ecological perspective, students will critically examine the social and cultural influences that shape the ways people learn about and express their sexuality, for example; in relation to gender roles, the concept of body image, discrimination, equity, the media, culturally based

60 Barbara Collins. Consistent or conflicting? Sexual health legislation and young people's rights in New Zealand. SPJNZ, issue 15, December 2000.

61 Explaining and Addressing Gender Differences in the New Zealand Compulsory School Sector: A Literature Review. (1999). Wellington: Ministry of Education.

62 The other areas are: mental health, food and nutrition, body care and physical safety, physical activity, sports studies, outdoor education.

values and beliefs, and the law. Sexuality education is enhanced when supportive school policies and practices are developed, links with relevant community agencies are made, and students are helped to identify and access support. Programmes for the prevention of sexual abuse are an important part of health education. However, these must be balanced at all levels by separate sexuality education programmes that emphasise the positive aspects of sexuality. To ensure that students do not receive confusing or mixed messages, these two programmes should not be taught concurrently or consecutively. Classroom programmes must be sensitively developed so that they respect the diverse values and beliefs of students and of the community."[63]

The Health and Physical Education Curriculum also has a number of legislative provisions for sexuality education in schools, including legislative requirements for School Boards of Trustees to inform and consult with the school community.

"Legislative Provisions for Sexuality Education in Schools
The Education Standards Act 2001 repealed sections 105C and 105D of the Education Act 1964. school boards of every state school must now implement the health curriculum in accordance with section 60B of the Education Act. Previously, schools had an option to exclude the sexuality education components of the curriculum. As outlined on page 53, at least once every two years the school board is required to prepare a draft statement about the delivery of the health curriculum and then to consult the school community before the school adopts the statement. The statement will include a clear description of the way in which the school will implement sexuality education."[64]

"Legislative Requirements for Consultation about the Implementation of the Health Curriculum
Section 60B of the Education Act 1989, as amended by the Education Standards Act 2001, outlines the legal requirements for state schools regarding the delivery of the health education components of the relevant national curriculum statements. At least once every two years, boards of trustees are required to produce a written statement about how the school will implement health education. The legislation requires schools to: • inform the school community about the content of the health education components of the curriculum; and • consult with members of the school community regarding the way in which the school should implement health education; and • describe, in broad terms, the health education needs of the school's students. Section 60B defines "school community" as meaning: • in the case of integrated schools, the parents of the students enrolled at the school and the school's proprietors; • in the case of any other school, the parents of the students enrolled at the school; • in every case, any other person whom the board of trustees considers is part of the school community for the purpose of developing the school health education programme. The board of trustees may use any method of consultation that it considers will best achieve the purpose of the consultation described above. A statement on the delivery of health education may not be adopted until the board has: • prepared a statement in draft; and • given members of the school community adequate opportunity to comment on the draft statement; and • considered any comments it receives. There is provision under section 25AA, as amended by the Education Standards Act 2001, for individual parents of students enrolled in any state school to write to the principal to request that their child/children be excluded from specified parts of the health programme related to sexuality education. The principal is required to ensure that the student is excluded from the relevant tuition and that the student is supervised during that time. This requirement does not extend to exclusion at any other time when a teacher deals with a question raised by another student that relates to sexuality education. The 1990 repeal of section 3 of the Contraception, Sterilisation and Abortion Act 1977 removed any legal impediment to young people of any age having access to advice on the use of contraception or to the supply of contraceptive devices. However, decisions to include contraceptive education as part of the sexuality education component of the school health programme must be considered within the requirements of the Education Act 1989 (as amended in 2001), which are outlined above."65

EDUCATION REVIEW OFFICE. (APRIL 2001). THE NEW ZEALAND CURRICULUM: AN ERO PERSPECTIVE. WELLINGTON.
In this review by ERO of the Health and Physical Education Curriculum, there is an acknowledgement of the possible impediments to successful implementation of the curriculum, especially when School Boards are required to consult with the school community before implementation of the sexual health curricula.

"Public pressure could influence the implementation of the curriculum, for example, in the areas of sexuality, mental health and sport education. The curriculum supports personal achievement in sport together with attitudes of

63 Ministry of Education. (1999). Health and Physical Education in the New Zealand Curriculum. Wellington: Learning Media. Page 38.

64 Ibid, page 39.

65 Ibid, page 53.

participation, cooperation and fair play. Some sport organisations would see sport education as encouraging more competition. Similarly, organisations that oppose abortion and advocate sexual abstinence can influence the content of sexuality education. School coordinators will need ongoing support in selecting appropriate resources and delivering programmes that provide adequate coverage of curriculum learning outcomes."[66]

CIRCULAR 1999/21 – HIV/AIDS AND OTHER BLOOD BORNE DISEASES. (1 MARCH, 2004).
This Circular was issued by the Ministry of Education to schools to provide guidelines on how to deal with risks associated with HIV/AIDS and other blood borne viruses in schools.

THE NEW ZEALAND CURRICULUM: DRAFT FOR CONSULTATION 2006. (2006). WELLINGTON: MINISTRY OF EDUCATION.
Currently the curriculum is under revision. The Ministry of Education has distributed the draft New Zealand Curriculum document for comment from stakeholders. The Minister of Women's Affairs, Lianne Dalziel, in an address to the New Zealand Family Planning Association, states the need for a review of sexuality in schools.

> "Good sexual and reproductive health is not just a health issue; it impacts on people's lives and their families and communities. These are complex issues and there is no single, simple solution. It is critical that we accept the realities of sexual behaviour and address these realities. This is why we are engaging in a review of sexuality education in our schools – we need excellent resources, confident and capable teachers and effective programmes that respond to young people's needs in a positive way."[67]

In the "New Zealand Curriculum: Draft for consultation 2006," sexuality education is considered one of the seven[68] key areas of learning within the Health and Physical Education Curriculum. In the new curriculum there are also three related subject areas that make up Health and Physical Education: health education, physical education and home economics.

> "In health education, students develop their understanding of the factors that influence the health of individuals, groups and society: lifestyle, economic, social, cultural, political, and environmental. Students develop competencies for mental wellness, reproductive health and positive sexuality, and for safety management…Students build resilience through strengthening their personal identity and self-worth, through managing change and loss, and through engaging in processes for responsible decision making."[69]

3. Ministry Of Social Development

The Ministry of Social Development "provides whole-of-social-sector leadership and delivers policy advice and social services to improve social outcomes for children and young people, working age people, older people, and families and communities."[70] As part of the ministries portfolio, there is a strong youth and family focus with the Ministry of Youth Development and Department of Child, Youth and Family Services falling within the Ministry, including providing advice to the Office of the Children's Commissioner and the Families Commission.

Two priority areas highlighted in the Ministry of Social Development's 'Statement of Intent 2006' are Children and Young People, and Families and Whanau. The Ministry of Social Development has as part of its role a number of responsibilities in regards to Children and Young People, and Families and Whanau. Some of those responsibilities include:

Undertaking research on the wellbeing of families;
Providing policy advice on programmes and services that encourage the development of well-functioning, supportive families;
Chairing the interagency Taskforce for Action on Violence within Families;
Providing advice on Child and Youth policy;
Coordinating policy across government sectors;
Leading the 'Agenda for Children' and the 'Youth Development Strategy Aotearoa';

66 Education Review Office. (April 2001). The New Zealand Curriculum: An ERO Perspective. Wellington. Visited website, 20 November 2006.
http://www.ero.govt.nz/ero/publishing.nsf/Content/A5284E94819DE25CCC25704A00167383?Open

67 Women's Affairs Minister Lianne Dalziel, Address to NZ Family Planning Association, Netball Centre, South Hagley Park, Christchurch, 10.00am Friday 25 November 2005.
http://www.mwa.govt.nz/newsandpubs/speeches/speeches05/fpa.html/view?searchterm=reproductive%20health, Accessed on 3 November 2006.

68 The other areas are: mental health, food and nutrition, body care and physical safety, physical activity, sports studies, outdoor education.

69 The New Zealand Curriculum: Draft for consultation 2006. (2006). Wellington: Ministry of Education. Page 17.

70 Ministry of Social Development, Statement of Intent 2006.

Coordinating the governments work programme to implement the United Nations Convention on the Rights of the Child (UNCROC).[71]

In May 2002 the Ministry of Social Development released the report, 'Exploring Good Outcomes for Young People: A research report.' The report was a compilation of views of families, young people and service providers on what constitute 'good outcomes' for young people, which also incorporated separate Maori, Pakeha and Pacific reports on what constituted 'good outcomes' for their young people. The Maori report found that the "desirable outcomes for young people were seen to be that they were happy, confident, respectful, responsible, secure in their identity as Maori, with strong whanau and peer relationships, and with the education and qualifications necessary to give them options and choices in their lives."[72] Overall, all groups highlighted the significance of young people having the active support of their whanau. Service Providers who were interviewed believed "that the effects of whanau support and functioning, and in particular the lack of this, were intergenerational. Young people who were not supported, encouraged and nurtured would be less likely to be able to provide those things for their own children."[73]

In June 2002 the government launched "The Agenda for Children," a strategy for improving the lives of children. The Agenda for Children follows a Whole Child Approach, which emphasises the rights and interest of the child. This Agenda is part of the government response to the United Nations Convention on the Rights of the Child (UNCROC).

In 2006 the Ministry of Social Development, in partnership with the Health Research Council of New Zealand, has instigated the design of a longitudinal study of New Zealand children and families, which would continue for up to 25 years. The study will help the government develop social policy, which is cognisant of social and demographic factors in children's development and that affect families. The development phase of the research is being undertaken by a multi-disciplinary team of University of Auckland, Otago and Victoria University researchers, and is being overseen by an executive steering committee with multi-ministry and agency representatives.

4. Ministry Of Youth Development (Formerly Known As Youth Affairs)

The Ministry of Youth Development promotes the interests of young people aged between 12 and 24 years inclusive. The Ministry falls under the umbrella of the Ministry of Social Development and is located within the Social Services Policy Group.

MINISTRY OF YOUTH AFFAIRS. (1996). A GUIDE TO REALISING THE POTENTIAL FOR GOVERNMENT DEPARTMENTS AND AGENCIES: DEVELOPING AND ANALYSING GOVERNMENT YOUTH POLICIES IN NEW ZEALAND. WELLINGTON. MINISTRY OF YOUTH AFFAIRS.

In the Ministry of Youth Affairs list of priority areas for young people, one significant area identified was wellbeing. The five priority issues identified in the area of wellbeing were: youth suicide; road crashes; alcohol, tobacco and drug use; teenage unplanned pregnancies; and sexually transmitted diseases.

In the late 1990's, the Ministry of Youth Development commissioned three papers on young people's sexual and reproductive health with a focus on young men.

OPTIONS FOR ENHANCING THE EFFECTIVENESS OF GOVERNMENT POLICY ON YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH (NOVEMBER 1998)

> "This paper looks at the issues underlying teenage pregnancy and sexually transmitted diseases and how these are linked. It covers things such as young people's lack of knowledge, skills and information to make good decisions. The paper identified areas Youth Affairs could focus its work on such as: improving information and access to services, contraception and condoms."[74]

YOUNG MEN'S INVOLVEMENT IN SEXUAL AND REPRODUCTIVE HEALTH: CURRENT STATUS AND INITIATIVES (MAY 1999)

71 Ibid.

72 Ministry of Social Development (2002). 'Exploring Good Outcomes for Young People: A research report.' Page 45.

73 Ibid, page 46.

74 Ministry of Youth Development website, visited on 1 October 2006. http://www.myd.govt.nz/policyresearch/pastpolicyadvice/youngpeoplessexualandreproductiveh.aspx

> "This paper looks at how well current youth sexual and reproductive health strategies are working for young men. It examines how these are meeting young men's needs, and encouraging behaviour that will promote their and young women's sexual and reproductive wellbeing."[75]

YOUNG MEN'S INVOLVEMENT IN SEXUAL AND REPRODUCTIVE HEALTH: STRATEGIES (JUNE 1999)

> "This third Youth Affairs paper on the sexual and reproductive health of young men identifies areas for further work, focusing on young men, to improve all young people's sexual and reproductive health. Although the work areas are targeted at young men any new initiatives will also affect young women."[76]

YOUNG MALES: STRENGTHS-BASED AND MALE-FOCUSED APPROACHES. A REVIEW OF THE RESEARCH AND BEST EVIDENCE. (MARCH 2004)
This paper focuses on strengths-based and male-focused approaches to programme delivery for young males, especially young men at risk of harming themselves or others. A top priority highlighted in the report is the building of caring relationships with adults for any programme developed for young men.

5. Department Of Child, Youth And Family Services

The Department of Child, Youth and Family have the power to intervene to ensure children are protected, and are free from abuse (sexual, physical, other) or neglect. They also have the power to intervene to support a child who has behavioral problems. Areas include, working with the Police and the Courts, residential and care services, adoption information services and community agencies and organisations who work with children, young people and their families.

6. Ministry Of Justice

The Ministry of Justice covers a number of areas related to protecting New Zealanders from crime, violence and sexual assault and victimisation, which includes a focus on the rights and protection of the child, and providing sexual violence education programmes.

In 2001 the New Zealand Government set out a Crime Reduction Strategy, which is made up of seven priority areas for crime reduction: family violence and child abuse, other (community) violence and sexual violence, burglary, theft of and from cars, organised crime, serious traffic offending, youth offending and re-offending.

Priority area two of the Crime Reduction Strategy is 'Other (Community) Violence and Sexual Violence.' A major strategy introduced to combat 'Other (Community) Violence and Sexual Violence' by the Ministry of Justice / New Zealand Police is the 'Safer Communities Action Plan to reduce community Violence and Sexual Violence,' which is the government's policy response to reducing community violence and sexual violence.

PROTECTING OUR INNOCENCE: NEW ZEALAND'S NATIONAL PLAN OF ACTION AGAINST THE COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN. (FEBRUARY 2002). WELLINGTON: MINISTRY OF JUSTICE.
In 2001 the Ministry of Justice released the National Plan of Action, a multi-agency government effort to eliminate the commercial sexual exploitation of children. This Plan of Action was one of the New Zealand Governments responses to the United Nations Conventions on the Rights of the Child (UNCROC).

> "New Zealand is a State Party to the United Nations Convention on the Rights of the Child (UNCROC). The mandate for the Plan of Action can be found in Articles 34, 35 and 39 of the Convention. Articles 34 and 35 state the need to protect children from child prostitution, child pornography and from being trafficked for sexual purposes. Article 39 creates an obligation on state parties to take all appropriate measures to promote the physical and psychological recovery and social reintegration of child victims. These themes have been incorporated into the Plan of Action under thirteen objectives."[77]

As well as coming within the ambit of sexual and reproductive health in New Zealand, several of the 13 National Plan of Action objectives have specific relevance to sexual and reproductive health provision:

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75 ibid.

76 ibid.

77 Ministry of Justice. (2006). A Five-Year Stocktake of the Steps Taken by the New Zealand Government and Civil Society to Prevent the Commercial Sexual Exploitation of Children. (Page 7)

Objective 8: To ensure that children are educated to protect themselves against commercial sexual exploitation. The New Zealand Police offer a "Keeping Ourselves Safe" programme to school children: "to teach young people understandings and skills they need to keep safe when meeting other people; to encourage those involved in abuse to seek help; and to raise awareness in the adult community of the need to keep young people safe."[78]
Objective 10: To provide health care and sex education for young people. In 2001 the government set out the Sexual and Reproductive Health Strategy, which is administered through the Ministry of Health. The Ministry provides direction in the form of the strategy, resources and public campaigns.
Objective 12: To enable children who have experienced commercial sexual exploitation to recover and reintegrate. This objective is administered by a number of government and non-government agencies, including: the Ministry of Social Development; Ministry of Youth Development; Department of Child, Youth and Family; Ministry of Justice; Housing New Zealand Corporation.[79]

THE NEW ZEALAND NATIONAL SURVEY OF CRIME VICTIMS. (MAY 2003). WELLINGTON: MINISTRY OF JUSTICE.
In this National Survey of Crime Victims, sexual victimisation is a significant area. However, as acknowledged by the authors, the reporting of incidences of sexual victimisation is low. The reasons for this include:

1. Victims do not identify that they may have experienced rape or sexual assault for example.
2. Victims may feel ashamed, embarrassed or believe that they 'asked for it.'
3. Victims may feel that by reporting the incident to authorities, the Police, will not take them seriously.

The key findings in the report relating to sexual victimisation include: most victims are women; most offenders are male; most victims know their offender. In regards to the implications for policy, the key implications are "the continued need for campaigns which stress, for example, that 'no means no' or that sexual violence within relationships (and within families) is criminal. Second…the need to continue to ensure that women (and men) who decide to report sexual victimisation to the Police are treated with respect."[80]

SAFER COMMUNITIES: ACTION PLAN TO REDUCE COMMUNITY VIOLENCE AND SEXUAL VIOLENCE. (JUNE 2004). WELLINGTON: MINISTRY OF JUSTICE.
The 'Safer Communities Action Plan to Reduce Community Violence and Sexual Violence' is the government's policy response to reducing community violence and sexual violence, and is multi-agency implemented. The four priority areas in the Action Plan are: attitudes to violence, alcohol related violence, violence in public places, and sexual violence. A significant focus of the Action Plan is on education and prevention initiatives.

The sexual violence education programmes teach young people about appropriate and inappropriate sexual behaviour, healthy relationships, and the development of strategies to deal with inappropriate behaviour. This is achieved by delivering various education programmes:

1. The Health and Physical Education Curriculum provides units on sexuality, sexual abuse and healthy relationships.
2. Keeping Ourselves Safe: a school-based programme primarily delivered by the New Zealand Police which relates to the prevention of sexual abuse.
3. 'Safe school' policies, procedures and guidelines adopted by schools to protect students and staff.
4. Netsafe: the Internet Safety Group devised Netsafe in order to educate parents, children and teachers of the possible harassment and sexual offending that can occur through the use of new technologies such as the internet and mobile phone.

However, there are a number of shortcomings with the sexual violence education programmes:

1. School's Board of Trustees are required by law to consult with, and seek agreement from, the school community as to the Health curriculum implemented in their school. Parents may request in writing that their child be excused from any part of the sexuality section in the Health curriculum.
2. School's have flexibility in what and how they deliver sexual abuse prevention programmes implemented in their schools, as well as the option of opting out. Parents may request that their child be excused from the programme.
3. There is a gap in knowledge of what constitutes healthy relationship behaviour for the general public, and thus what constitutes sexual violence, which has been identified in the 2003 New Zealand National Survey of Crime Victims report.

78 ibid, page 25.

79 Ibid.

80 The New Zealand National Survey of Crime Victims. (May 2003). Wellington: Ministry of Justice.

4. Different agencies are responsible for interventions but there is no coordinated approach to sexual violence.[81]

THE SEX INDUSTRY IN NEW ZEALAND: A LITERATURE REVIEW. (MARCH 2005). WELLINGTON: MINISTRY OF JUSTICE.
This report provides an overview of the sex industry in New Zealand since the passing of the Prostitution Reform Act 2003, the literature related to the sex industry in New Zealand, and provides an overview of overseas models of prostitution law reform.

THE NATURE AND EXTENT OF THE SEX INDUSTRY IN NEW ZEALAND: AN ESTIMATION. (APRIL 2005). WELLINGTON: MINISTRY OF JUSTICE.
This report provides an overview of the sex industry in New Zealand by compiling data from a telephone survey of the New Zealand Police districts and areas, and by including an audit of advertisements for commercial sexual services in Wellington and Auckland prepared by the New Zealand Prostitutes' Collective.

A FIVE-YEAR STOCKTAKE OF THE STEPS TAKEN BY THE NEW ZEALAND GOVERNMENT AND CIVIL SOCIETY TO PREVENT THE COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN. (2006). WELLINGTON: MINISTRY OF JUSTICE.
The 'Five-year Stocktake' provides a report on how "New Zealand's National Plan of Action Against the Commercial Sexual Exploitation of Children" has performed for five years from 2001 to 2006, and measures the progress the different government and non-government agencies have made in achieving the 13 objectives in the National Plan of Action.

7. Te Puni Kokiri

The Ministry of Maori Development (Te Puni Kokiri) has also played an important role in assisting with the establishment of many programmes. One of its roles is promoting health initiatives involving Maori participants.

In 1993, Te Puni Kokiri developed a discussion document "Te Ara Ahu Whakamua: Strategic Direction for Maori Health" which enabled the Ministry to focus on areas which were a priority for making a difference to Maori health. A key theme to emerge from this document was the need to let Maori determine their own futures. There was also the need to strengthen whanau (family) structures, for the acknowledgement of the diversity of Maori and the acceptance of greater personal responsibility for health.

SPECIFIC HEALTH POLICY DEVELOPMENTS:
Three major hui held during 1994 have ensured that Maori have a greater say in the way health services are delivered to Maori.

TE ARA AHU WHAKAMUA - THE MAORI HEALTH DECADE HUI
Held in Rotorua, this hui developed a shared vision of the future of Maori Health. It brought together Maori aspirations and aims and looked at what defined a healthy Maori. The hui also looked at the future to the year 2000, as well as the role of government agencies and ways of measuring Maori health performance.

MA TE MAORI E PURI TE MAIMOATANGA MAORI - MANAGED CARE BY MAORI
Held in Whanganui in December 1994, the hui helped Maori look at managed care and discuss how current structures may develop over the next few years. As a result more Maori are now providers of Maori health services with greater control over how such services are delivered to Maori.

HUI WHAI MARAMATANGA WHAI ORANGA - LIFTING THE VEIL, SECURING A FUTURE
WHAI MARAMATANGA WHAI ORANGA: REPORT OF THE HUI ON MAORI REPRODUCTIVE HEALTH & HIV/AIDS. (1995). WELLINGTON, NEW ZEALAND: TE PUNI KOKIRI.
Held in Papakura in March 1995, this hui worked to develop a strategy for Maori sexual reproductive health and HIV/AIDS. This was a valuable discussion because it enabled Maori to be part of the policy process and for policies to be initiated, which are specific to Maori and also look at issues for the future.

Two other reports produced by Te Puni Kokiri that relate to sexual and reproductive health that are important to this overview include:
Te Puni Kokiri.(1994a). Mate ketoketo/Arai kore – A report about HIV/AIDS and Maori. Wellington, New Zealand: Te Puni Kokiri.

81 Safer Communities: Action plan to reduce community violence and sexual violence. (June 2004). Wellington: Ministry of Justice.

Te Puni Kokiri(1994b). Te Runanga o Te Rarawa – Maori male adolescent health project. Wellington, New Zealand: Te Puni Kokiri.

8. Ministry Of Women's Affairs

Currently (2006) the Ministry of Women's Affairs is leading a cross-agency review of sexuality education in New Zealand secondary schools to gather information on how schools and communities are implementing sexuality education. The review will be conducted by ERO and is expected to be complete by the end of 2006. Pupils in years seven to 13, from a sample of 80 – 100 schools, will be included in the review.

The Ministry of Women's Affairs is largely the Ministry that oversees the implementation and development of the international declaration, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). The Minister of Women's Affairs, Lianne Dalziel, stated in a speech on 'Gender Equality in the Pacific Region' the government's position on the status of women.

> "In November 2004 the Minister of Women's Affairs and the Minister of Foreign Affairs jointly agreed to a set of priorities for New Zealand's international work in relation to issues concerning the status of women and those priorities have guided the joint work of both Ministries. These priorities relate to:
> - defending women's sexual health and reproductive rights
> - reducing violence against women; and
> - promoting gender mainstreaming."[82]

The Ministry of Women's Affairs also works with the Ministry of Justice in implementing the Crime Reduction Strategy, which is made up of seven priority areas for crime reduction: family violence and child abuse, other (community) violence and sexual violence, burglary, theft of and from cars, organised crime, serious traffic offending, youth offending and re-offending. The Minister in her speech on 'Gender Equality in the Pacific Region' also states the correlation between violence and poor sexual and reproductive health outcomes.

> "The linkage between violence and poor sexual and reproductive health outcomes is often overlooked. The public response to violence is rightly one of empathy, for those affected, but the public reaction to those who are affected by unplanned pregnancy and infection from STIs such as chlamydia, is more likely to be judgmental and critical. This attitude also ignores the fact that children who grow up in an atmosphere of violence are at increased risk of early unsafe risky sexual behaviour. It also ignores the fact that coercion is often an aspect of sexual activity; that women do not necessarily have the option to 'just say no' or to insist on condom use."[83]

ACTION PLAN FOR NEW ZEALAND WOMEN, MINISTRY OF WOMEN'S AFFAIRS, MARCH 2004.
The Ministry has also implemented in 2004 The Action Plan for New Zealand Women. The Action Plan for New Zealand Women was introduced in March 2004.[84] It "is an integrated government approach to improving the circumstances of New Zealand women. Actions combine to improve outcomes for women and their families/whanau in the workplace, the home, the community, and as members of New Zealand society."[85] The Action Plan has three priority areas: to improve the economic independence of women (Economic Sustainability); to achieve greater work-life balance for families (Work-life Balance); and to improve the quality of life of New Zealand women (Well-being). The Ministry of Women's Affairs will be providing policy directions and coordinating the implementation of the Action Plan with other agencies.

Within the Well-being priority area, one of the actions required to improve the health of women is the focus on sexual and reproductive health, where the lead agencies in this action are the Ministry of Health and the District Health Boards. The specific actions include: "Implement the Sexual and Reproductive Health Strategy to reduce the incidence of sexually transmitted infections and number of unwanted pregnancies with a particular focus on teenage pregnancies. Develop a

82 Speech by Hon Lianne Dalziel, 3/10/2006, "Gender Equality in the Pacific region," Grand Hall, Parliament, Wellington.
http://www.beehive.govt.nz/ViewDocument.aspx?DocumentID=27284
Accessed on 3 November 2006.

83 Ibid.

84 Ministry of Women's Affairs (2004). Action Plan for New Zealand Women.

85 Ibid, page 4.

framework for a cross-sector approach to reducing teenage pregnancy. Implement a public health campaign on sexual and reproductive health and survey sexual and reproductive health behaviours every two years."[86]

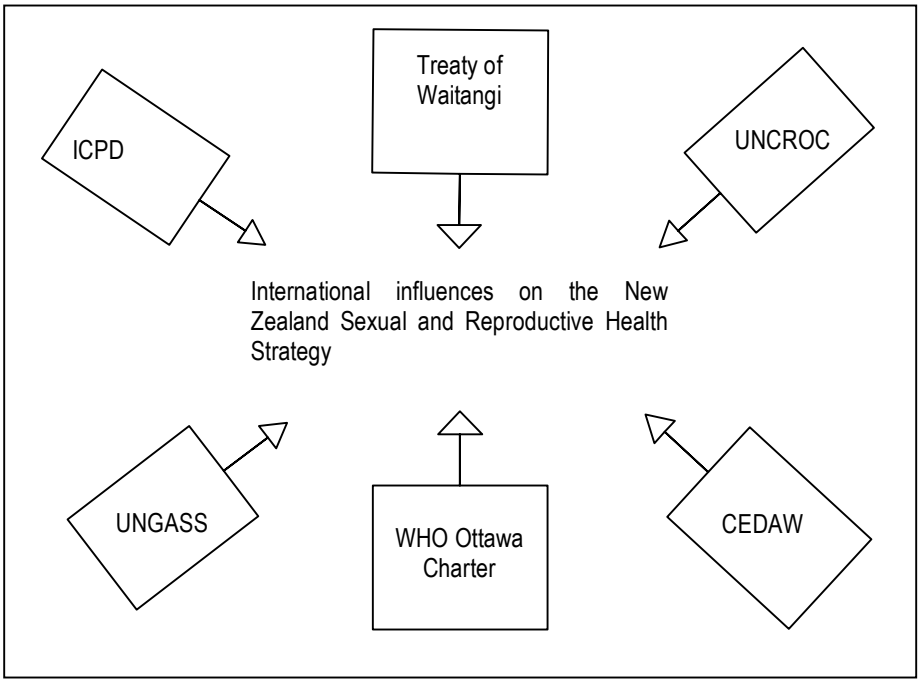
The Action Plan meets a number of international obligations the New Zealand Government is a signatory to "particularly those related to the Beijing Declaration and Platform for Action (the Fourth World Conference on Women 1995), Beijing +5 and the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). The Plan provides a mechanism for the government to deliver a coordinated response, both to the CEDAW Committee's concerns and to the priorities identified in the consultation process, which will achieve economic sustainability and personal well-being for women."[87] The Plan is expected to be reviewed and updated in 2006.

Ultimately, in regards to sexual and reproductive health in New Zealand, the Sexual and Reproductive Health Strategy and Sexual and Reproductive Health Resource Book are the key documents in defining and guiding sexual and reproductive health. As can be seen from this brief scoping of the sexual and reproductive health sector in New Zealand, the provision of sexual and reproductive health policy, service and intervention is spread across different ministries and is therefore fragmented and uncoordinated in approach.

The International Scene

In a prepared speech to the 2004 High-Level Intergovernmental Meeting to Review Regional Implementation of the Beijing Platform for Action, held in Bangkok, New Zealand's representative at the forum stated the government's commitment to the international treaties it is a signatory to:

> "New Zealand would like to take this opportunity to reaffirm the importance of sexual and reproductive health rights as set down at Cairo in the International Conference on Population and Development (ICPD) in 1994 and Beijing in 1995. All too often, women suffer or die in circumstances that are preventable. They die because they are uninformed about their choices; and because they have no access to safe, effective, and affordable methods of family planning; and, because they have no freedom to decide when to have sex and when to have children. The agreements reached on sexual and reproductive health remain as important today as they were at Cairo and Beijing, and we wish once again to reaffirm New Zealand's commitment to honouring them. The health of women, and through them the health of their families and communities, is at the very heart of those commitments."[88]



International influences on the New Zealand Sexual and Reproductive Health Strategy

Along with the Treaty of Waitangi, government responsibility for achieving sexual and reproductive health for Maori (and all New Zealanders) is underpinned by compliance with various international instruments. The New Zealand government has ratified a number

86 Ibid, page 17.

87 Ibid, page 25.

88 Statements and Speeches by Ministry Representatives 2004, High-Level Intergovernmental Meeting to Review Regional Implementation of the Beijing Platform for Action, New Zealand Statement by Sarah Craig, Bangkok, 7 September 2004. From: NZ Ministry of Foreign Affairs and Trade website, accessed on 3 November 2006.
http://www.mfat.govt.nz/Media-and-publications/Media/MFAT-speeches/2004/0-7-September-2004.php

of international treaties that adopt a 'rights-based' approach to sexual and reproductive health.
The international declarations that helped shape the New Zealand Sexual and Reproductive Health Strategy include:

- Charter for the Elimination of Discrimination Against Women (CEDAW)
- Conference on Population and Development Programme of Action +5 (ICPD)
- United Nations HIV/AIDS Declaration (UNGASS)
- Beijing+5 Platform of Action (ICPD)
- United Nations Convention on the Rights of Children (UNCROC).
  (Sexual and Reproductive Health Strategy, Phase One, 2001)

Before looking at each of the international declarations, it is important to understand the Indigenous and international context to the development of the New Zealand Sexual and Reproductive Health Strategy.

Indigenous Peoples And Sexual And Reproductive Health History

International and domestic ways of dealing with sexual and reproductive health needs contrast with each other at crucial points. Domestic programmes, particularly Indigenous innovations and practices, are cognisant of a historical context and deal with the health needs of their communities with this as part of a holistic approach. The historical context, defined by a colonial project, is often infused with attempts to regulate Indigenous sexual and reproductive health at its most fundamental level. Referring to the colonising regime of Australia, Thomas notes that:[89]

> "… the control of the sexuality of Indigenous people, especially Indigenous women (but rarely the sexual partners if they were white men), was a central element of colonial policy and power. The representation of Indigenous people as a source of STD's in non-Indigenous Australians was a justification of the policy of police examinations of Indigenous Peoples followed by isolation and incarceration of those found with STD's in lock hospitals … on islands in Western Australia and Queensland."

This graphic illustration of the treatment of Indigenous Peoples by the colonial project compels various Indigenous attempts to protect their own views of sexuality, reproduction, and wellbeing in general. In their publication which attempts to deal with the effects of colonisation on their people's sexual and reproductive health, for instance, Castro-Palaganos et al warn of the need to capture and document Indigenous health knowledge and processes before intrusion by modernity[90]. Their particular approach to the issues facing the Cordillera people of Northern America is typical of most Indigenous Peoples; they maintain that a holistic model of sexual and reproductive health needs to be resurrected and protected before a complete derogation from their own models of wellbeing occurs.

Many Indigenous health organisations have heeded the call for holistic models of sexual and reproductive health. Ngangganawili Aboriginal Health Service is an example of a model that uses a holistic approach to sexual health programmes: as an aboriginal community controlled health organisation it places emphasis on parenting education and so is not intent on solely focusing on youth, recognising the need to span generations to address the wider familial issues.[91] They are listed alongside other similar organisations in Western Australia governmental resources in the area of family health,[92] which have tended to place greater emphasis on targeting youth in dealing with sexual and reproductive health.

Other examples of culturally specific approaches to reproductive and sexual health, against a wider context of colonisation, proliferate amongst Indigenous groups. However, sometimes their attempts to provide for their own people have been frustrated at international levels. Structured adjustment policies (SAPs) of the 1980s, for example, which immediately succeeded bailouts by wealthy nations, saw cutbacks in health, which resulted in the privatisation of health centres. Ultimately Indigenous Peoples were restricted to resorting to mainstream organisations to access healthcare generally. This of course included access to sexual and reproductive health at both educational and treatment strata.

At international fora, attempts to adopt a similar holistic approach to reproductive and sexual health emerge in the 1990s. Where, previously, women's health needs were regarded as best being met through contraception promotion solely, the breadth of reproduction health services had obviously to be catered for; instrumental in the move to a much wider regard of women's reproductive issues was the 1994 International Conference on Population and Development (ICPD) in Cairo.

89 Thomas, D (2004) Reading doctors' writing: Race, politics and power in Indigenous health research 1870 – 1969 Canberra: Aboriginal Studies Press p. 21.

90 Castro-Palaganos, E et al (2001) Mainstreaming Indigenous health knowledge and practices Quezon City: University of the Phillipines.

91http://www.dia.wa.gov.au/Publications/Files%5CWILUNA%20REPORT%20FINAL%20Nov%202004.pdf. For a description of the genesis of this clinic refer "Towards a benchmarking framework …"

92http://www.population.health.wa.gov.au/communicable/gdhr_resources/Appendices.pdf.

Although not necessarily mindful of the specific needs of Indigenous Peoples, it did recognise that family planning services needed to be integrated into the much more expansive service of reproductive health. Reproductive health was now defined in the ICPD-Plan of Action as[93]:

> "…the state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. [This] therefore implies that people are able to have a satisfying sex life and that they have a capability to reproduce and the freedom to decide if, when and how often to do so."

Sexual And Reproductive Health History

In 1945 the United Nations Charter and the Universal Declaration of Human Rights both set the stage for health to be considered as a crucial issue. In 1949 the Geneva Convention Relative to the Protection of Civilians in Times of War brought reproductive health within the ambit of humanitarian law; although not expressly mentioning reproductive health, it does refer to 'maternity cases' as well as a need to protect women 'against rape, enforced prostitution, or any form of indecent assault'.[94]

Further protection was seen to be needed, but it was not until 1976, with the international community conceding the need for changes, that another covenant was added to the Human Rights Declaration, which would achieve this. Thus issues of gender, reproductive health and refugees, including those not under the protection of a host country, could be potentially protected. Further, The International Covenant on Economic, Social and Cultural Rights (ICESC), Article 12, which came into force on 3 January 1976, goes beyond the Universal Declaration's right to health. Rather, Article 12 states:

(1). The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

(2). The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:

- (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- (b) The improvement of all aspects of environmental and industrial hygiene;
- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Reproductive health is not mentioned in name but is catered for to some extent by 12 (2)(a). Expanding on the substantive content of article 12, the UN General Comment No. 14 states:

> "The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child" (art. 12.2 (a)) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information."

International Declarations Influencing New Zealand's Sexual And Reproductive Health Policy

1994 United Nations' International Conference on Population and Development (ICPD) in Cairo

As one of the 179 signatory countries to the ICPD Programme of Action (1995 – 2015), New Zealand is obligated to improve sexual and reproductive health for New Zealanders. In 1999 ICPD+5 was held in The Hague, and in 2004 countries reaffirmed their commitment to the Programme of Action at the ICPD+10 meetings.

The New Zealand Government is committed to The International Conference on Population and Development (ICPD) Programme of Action (1994)[95], and The ICPD +5 (1999) and the ICPD +10 (2004). The ICPD Programme of Action includes commitments to reproductive rights and reproductive health including, for example, access to information and access to safe

93 ICPD Plan of Action.

94 refer to articles 17 and 27.

95 United Nations, Summary of the Programme of Action of the International Conference on Population and Development, International Conference on Population and Development, New York, 1994.

effective methods of family planning, mutually respectful and equitable gender relations, meeting the educational needs of adolescents and, reproductive health through the primary health care system[96].

The ICPD Charter also refers to reproductive health in relation to Indigenous People. It states, "the specific needs of Indigenous People, including primary health care and reproductive health services should be recognised. In full collaboration with Indigenous People, data on their demographic characteristics should be complied and integrated into the national data-collection system. The cultures of Indigenous people need to be respected. Indigenous people should be able to manage their lands, and the natural resources and ecosystems upon which they depend should be protected and restored"[97].

IN 1998 THE NEW ZEALAND PARLIAMENTARIANS GROUP ON POPULATION AND DEVELOPMENT (NZPPD) was established as a result of this conference to support the goals of the ICPD Programme of Action. In December 2006 the NZPPD will be holding an 'Open hearing on youth sexual and reproductive health.'

THE INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF) CHARTER ON SEXUAL AND REPRODUCTIVE RIGHTS is intended to act as a tool to assist non-Governmental Organisations (NGOs) to hold Governments accountable for commitments they have made in human rights in general, and sexual and reproductive rights in particular. These treaties have the status of international law, and therefore States, which have ratified them, have entered into legally binding obligations to honour them within the legislative frameworks of their own countries[98].

The IPPF Charter identifies a broad range of sexual and reproductive health issues, which fall within the scope of twelve basic human rights sourced from four international treaties. The treaties include The International Covenant on Civil and Political Rights, The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and The Convention on the Rights of the Child (The Children's Convention). Standards from the ICPD Programme of Action are also cited in the IPPF Charter under each of the twelve human rights identified. The New Zealand Government has ratified all agreements on which the IPPF Charter is based.

1979 THE CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN (CEDAW)
The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was adopted by the United Nations in 1979. The New Zealand Government ratified the Convention on 10 January 1985. The adoption of CEDAW ensures there is no discrimination against women and ensures that women have equal access and participation in all aspects of society.

CEDAW highlighted women's reproductive health rights and social, cultural and economic inequity. The Convention comprises a preamble and 30 articles, and establishes an agenda for action to end discrimination which itself is defined as "...any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."

By accepting the Convention, States commit themselves to undertake a series of measures to end discrimination against women in all forms, including:

- to incorporate the principle of equality of men and women in their legal system, abolish all discriminatory laws and adopt appropriate ones prohibiting discrimination against women;
- to establish tribunals and other public institutions to ensure the effective protection of women against discrimination; and
- to ensure elimination of all acts of discrimination against women by persons, organisations or enterprises.

In particular, Article 12 of the Convention requires States to 'eliminate discrimination in access to health services throughout the life cycle, particularly in the areas of family planning, pregnancy and confinement, and the post-natal period'.

Further support came in 1999 when CEDAW made recommendations that violence against women be addressed in their General Recommendations No. 24 on Women and Health. STIs and HIV/AIDs, female genital mutilation, amongst other

96 ibid, p13.

97 United Nations, 1994 Chapter VI, p12.

98 International Planned Parenthood Federation (IPPF) "Summary on the Charter on Sexual and Reproductive Rights" www.ippf.org/charter/summary.htm

issues, required tackling, due to the fact that: "access to health care, including reproductive health, is a basic right under the Convention on the Elimination of All Forms of Discrimination against Women."[99]

The provisions of the Convention are legally binding to those countries that have ratified it.

The progress evident in the 1999 recommendations came on the heels of considerable earlier advancement within the arena of international women's health. Although there was a move away from population control and demographic targets towards holism, it was the International Conference on Population and Development (ICPD) in 1994, together with the Fourth World Conference on Women (FWCW), that encouraged a turn towards an empowerment of women and their reproductive health[100] at an international level. In particular the ICPD acknowledged the inextricable link between reproductive rights and basic human rights, a stance affirmed by FWCW.

The ICPD conference was important for a number of reasons. It announced a change in the fundamental view of women's health: healthy reproductive lives were important, and finally there was an emphasis on promoting services which would effect reproductive health. Men also were to have a greater role to play in the delivery of services.

Despite the evident paradigm shift that occurred with the ICPD conference, and notwithstanding its concession that reproductive health lies within the community, it is to be noted that participants' foci is on reproductive health as it affects women. Pushes for change may emanate from Indigenous Peoples who have traditionally felt that reproductive health is an issue that spans gender and age and does not rest solely with women.

Along with CEDAW the Beijing Platform for Action confirms women's rights to health information and services including sexual and reproductive health services[101]. The Beijing Platform for Action stated unequivocally that:

> "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the physical integrity on the human body, require mutual respect and the willingness to accept responsibility for the consequences of sexual behaviour."[102]

The Commonwealth Medical Association's report concerning a Woman's Right to Health, including sexual and reproductive health, outlines a number of indicators in monitoring women's health (in relation to CEDAW and the Beijing +5) as an important step towards establishing international guidelines for human rights violations of women's health rights. The report notes that "those working to measure States' compliance with human rights treaties should liaise closely with those working on statistical measures of health". The report further states "Indicators that can measure health outcomes are needed, as well as, quality of services; utilisation of services; socio cultural barriers and empowerment"[103].

The report includes, for example, the following indicators of women's health which are useful in considering indicators for Maori sexual and reproductive health including: accessibility of health services; availability of health information, use of health services by women; proportion of health budget allocated to women's and adolescent health programmes; status as regards poverty, nutrition, educational and employment functional literacy levels; women's awareness of health risks; women's awareness of rights to the enjoyment of health; proportion of women using health services; proportion of women requesting special health services; representation of women on health and safety bodies; representation of women on advisory and policy-forming bodies.

1989 UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD (UNCROC)
In 1993 New Zealand signed up to the United Nations Convention on the Rights of the Child.

99 Article 12.

100 http://www.forcedmigration.org/guides/fmo031/fmo031-2.htm

101 Commonwealth Medical Association A Woman's Right to Health, Including Sexual and reproductive health. Report of a Roundtable held in Toronto, Canada 26-28 September 1996.

102 ibid, p15.

103 Commonwealth Medical Association, p19.

In 2001 the New Zealand Government, through the Ministry of Justice, devised a multi-agency plan of action to stop the sexual exploitation of children. The Ministry of Justice released the document, "Protecting our Innocence: National Plan of Action against the Commercial Sexual Exploitation of Children," which outlined thirteen objectives on how to end sexual exploitation of children. "The mandate for the Plan of Action can be found in Articles 34, 35 and 39 of the Convention. Articles 34 and 35 state the need to protect children from child prostitution, child pornography and from being trafficked for sexual purposes. Article 39 creates an obligation on state parties to take all appropriate measures to promote the physical and psychological recovery and social reintegration of child victims."[104]

2001 UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION ON HIV/AIDS (UNGASS)
In 2001 the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) adopted the Declaration of Commitment on HIV/AIDS, which also had specific actions for combating HIV/AIDS.

In 2005 world leaders asserted their commitment to achieve equal access to reproductive health by 2015. They adopted the Summit Outcome recommended by the General Assembly, thereby agreeing to integrate access to reproductive health into national strategies. This step would ensure their adherence to the Millenium Development Goals. The Summit Outcome also recommended that leaders increase assistance to poor countries where HIV/AIDS (amongst other infectious diseases) is burgeoning.

International participation in the fight against HIV/AIDS is matched in fervour by the push for celebrity involvement. Elizabeth Taylor, for instance, who is a veteran of the fight against AIDS, has her own website to this effect[105]. She is quoted in the UCLA AIDS Institute website as being "the Joan of Arc of AIDS activism".[106] Having provided 25 years of commitment, she has allegedly raised more than $10 million for people with AIDS[107]. She is lauded as having also founded amfAR, which has raised more than $233 million for research.[108]

Elizabeth Taylor has been heavily involved with Dr Arnold Klein, who established the Elizabeth Taylor endowment for the CARE Center and is a member of the David Geffen School of Medicine in UCLA. He realised the need for fundraising in the early 1980s – when AIDS care was rudimentary – and, because of an historical association with Taylor, enlisted her help. The outcome, he recounts, is unwavering support from Taylor in the Center's core activities.

There are signs, however, that celebrity support for HIV/AIDS is weakening, with a host of other causes taking priority. Times Staff Writer, Tina Daunt, reveals the move of celebrities from supporting AIDS causes to others such as breast cancer, testicular cancer, environmental causes and tsunami relief.[109] She attributes this to " … a perception that AIDS now affects only developing nations instead of the U.S., where ever-improving medical cocktails are helping those with HIV live longer". Caplan reflects on the place of celebrities in lifestyle and treatment for diseases generally[110]:

> "It is because celebrities are so powerful and influence so much of our thinking that it is wrong for them to take advantage of our trust by hawking the values of a certain treatment when other treatments, including lifestyle changes, may benefit us more."

Since the deaths of such celebrities as Rock Hudson and Freddie Mercury, their peers have closely engaged with research into, and treatments around, the AIDS epidemic. The epoch of AIDS has been largely defined by the evolution of drugs to treat it. AZT was the first such drug; activists rallied to have its initial cost of $10,000 per year reduced[111] which made it much more accessible to the public although it still remained out of reach of the millions infected in Africa. In 1996 the inception of protease inhibitors marked a turn around in the treatment of AIDS, where, as of June 1998 "The New York Times has published only one obituary in which the cause of death was given as AIDS."[112] Further issues arise, such as the perceived glamour of having HIV/AIDS: advertisements of muscular healthy men scaling mountains whilst adhering to HAART regimes

104 A Five-Year Stocktake of the Steps Taken by the New Zealand Government and Civil Society to Prevent the Commercial Sexual Exploitation of Children. (2006, page 7).

105 http://www.elizabethtayloraidsfoundation.org/

106 http://www.uclaaidsinstitute.org/care/etef_25years.php

107 http://www.uclaaidsinstitute.org/care/etef_25years.

108 http://www.uclaaidsinstitute.org/care/etef_25years

109 http://www.latimes.com/entertainment/news/cl-et-aids14jun14,0,50790.story

110 http://www.webmd.com/content/Article/123/115150.htm?pagenumber=4

111 http://www.thebody.com/encyclo/artists.html

112 http://www.thebody.com/encyclo/artists.html

were seen to be influencing some people towards having unsafe sex. The Food and Drug Administration, following complaints from AIDS activists, forced pharmaceutical companies to review the tenor of their advertisements[113].

The oft-cited success of HIV/AIDS antiretrovirals has been cold comfort to those Third World countries, such as Africa, who are unable to access the medications. International organisations such as UNAIDS aim to meet the Millenium Development Goal of halting and beginning to reverse the spread of HIV/AIDS by 2015. UNAIDS is the Joint United Nations Programme on HIV/AIDS, and is pan-organisational. Heads of State and Government Representatives of 189 nations have ratified the Declaration of Commitment on HIV/AIDS[114] under the auspices of UNAIDS, and there is special focus on the plight of Africans and other Third World citizens, who are disproportionately affected.

WHO cites that, by the end of 2005, only 17% of the 4.7 million people in sub-Saharan Africa that needed treatment with anti-retroviral drugs had access to them.[115] Lack of national healthcare systems means an inability to cope with the sheer numbers of patients who need the medicines and thus it is up to individuals to pay for their own drugs. Many, of course, do not have the resources to access the medicines.[116] Despite GlaxoSmithKline's moves to make some of the antiretroviral drugs available cheaply to the poorest countries since 2000, access to the more effective and newer drugs, particularly effective in cases where sufferers become resistant to the first line of treatment, remains a problem.

As the bleak reality of a high numbers of sufferers, together with little assistance from the West, becomes ever more evident to African leaders, so does the option of producing home-grown medicines. As a consequence, Africa is planning to manufacture its own HIV drugs; Quality Chemicals, which has formed a partnership with Indian pharmaceutical Cipla, for instance, plans to be operational from June 2007.[117] Patent laws make access to cheap medicines extremely difficult; drugs like Abacavir are expensive to make and so producing cheaper models of new molecules is stymied. However, companies like Quality Chemicals may avail themselves of WTO rules, where the world's poorest countries can copy drugs without breaking patent laws.[118]

These problems are often set against a backdrop of dissension between key benefactors. The US insists that other industrialised countries step up to contribute more financial assistance to developing countries. However the EU diverges from the US, promoting the use of condoms instead of the line commonly adopted by the US – that of abstinence[119].

In 2003 WHO and UNAIDS set a target of treating 3 million HIV-infected individuals in developing countries by the end of 2005.[120] This was not achieved, with only 1 million receiving antiretroviral drugs. Half of the recipients live in sub-Saharan Africa where 60% of the entire world's HIV positive patients live.[121] Although $18 billion of the $27 billion in government donations earmarked for treatments has yet to show itself, WHO remains upbeat and cites success on other fronts, such as the number of volunteers who have been brought into developing countries to assist in providing care to AIDS sufferers.

The importance of traditional healing is seldom mentioned on mainstream websites. Interestingly, the UNAIDS website did devote a page to traditional healers, recognising that their forms of healing outnumber allopathic practitioners in many developing countries. The website outlines the benefits of their healing practices but not so much their outcomes; their use is relegated mainly to providing psychosocial support to those with HIV/AIDS, or for the treatment of the symptoms of HIV/AIDS. Under this latter category UNAIDS sees the need for some collaborative approaches between allopathic and traditional healers for dealing with the epidemic.

"New Scientist" discusses the potential of herbal remedies in combating the symptoms of HIV/AIDS and even reversing its effects.[122] In South Africa, it was discovered in 2001 that *insisa* – translating as "the one that dispels darkness and known by the West as Sutherlandia – has been used in treating HIV/AIDS with remarkable results. Clinical tests of its efficacy were to have followed. Other Indigenous herbal remedies and spiritual interventions may well prove effective and merit further research.

113 http://www.sfgate.com/cgi-bin/article.cgi?file=/c/a/2002/11/25/MN31554.DTL

114 http://www.unaids.org/en/Issues/Prevention_treatment/default.asp

115 http://news.bbc.co.uk/2/hi/business/5027532.stm

116 http://news.bbc.co.uk/2/hi/business/5027532.stm

117 http://news.bbc.co.uk/2/hi/business/5027532.stm

118 http://news.bbc.co.uk/2/hi/business/5027532.stm.

119 http://www.newscientist.com/channel/health/hiv/dn7604-who-misses-hiv-targets-but-makes-progress-.html

120 http://www.newscientist.com/channel/health/hiv/dn7604-who-misses-hiv-targets-but-makes-progress-.html

121 http://www.newscientist.com/channel/health/hiv/dn7604-who-misses-hiv-targets-but-makes-progress-.htm

122 http://www.newscientist.com/channel/health/hiv/dn1632

1986 OTTAWA CHARTER AND THE WORLD HEALTH ORGANISATION (WHO)

Along with the number of international treaties that the New Zealand Government has ratified, the government also works within the ambit of the World Health Organisation.

In 1948 the United Nations established the World Health Organisation to meet the objective of assisting the world's citizens to attain optimum health.[123] WHO's constitution refers to health being a state of complete physical, social and mental wellbeing, not merely an absence of illness or infirmity.[124] The Organisation is governed by 192 member States throughout the World Health Assembly; the World Health Assembly in turn is responsible for approving the WHO programme and considering major policies.[125]

At the First International Conference on Health Promotion held in Ottawa on 21 November 1986, the Ottawa Charter for Health Promotion was initiated. The Ottawa Charter is the framework for action to promote health; build healthy public policy, create supportive environments, strengthen community action, develop personal skills and reorient the health sector. Health promotion is defined as "the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being."[126]

In their document "Country Perspectives on Reproductive Health Indicators" the Department of Reproductive Health and Research, of WHO met to review country experiences around strengthening information and research systems which would monitor reproductive health[127]. It emerged that there was a need to prevent an adhoc approach to the selection of indicators. Maintaining a strong emphasis on a scientific approach there was no mention of Indigenous Peoples; there was, however, an overriding focus on safe motherhood and perinatal issues. The document itself conceded that there was a need for research into other areas, including broad considerations such as abortion and violence against women, and that these areas could only receive a perfunctory mention as they were in need of further research before the process of identifying indicators could proceed. Reproductive health policy and HIV/AIDS were also included.

It appears that the predominant focus of the Department of Reproductive Health and Research is on contraception and natality. The Indigenous reader of WHO's literature generally could become disheartened at the dearth of discussion on Indigenous definitions of, and participation in, the sexual and reproductive health arenas. Although the WHO website does include information about Indigenous health it does not mention Indigenous reproductive and sexual health, although, of course, there is a large amount of detail on Third Nations' Peoples and the impact of HIV/AIDS on their communities. Following is a review of some of the publications[128]:

Global Compendium of Indigenous Health Research Institutions (2001) lists all major academic and governmental research institutions, which are engaging with Indigenous health issues. There did not appear to be specific mention of any institutions engaging with reproductive and sexual health although this is likely to be integrated as part of a holistic health engagement with Indigenous communities.

International Decade of the World's Indigenous People: report by the Secretariat – years 2002, 2001, 1998 – again, this publication does not expressly mention sexual and reproductive health but it does outline WHO's perception of the role of traditional healers in relation to allopathic practitioners in the general area of health. The 2002 report mentions HIV/AIDS and its impact on Indigenous Peoples.

The Health of Indigenous Peoples – Ethel Alderete[129] – does not refer to sexual and reproductive health generally but talks at some length about inadequacy of allopathic medicine generally and the need for an holistic approach to health.

123 http://www.who.int/about/en/

124 http://www.who.int/about/en/

125 see http://www.who.int/about/en for further information

126 http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

127 http://www.who.int/reproductive-health/publications/HRP_97_27/HRP_97_27_chapter1.en.html

128 These can be accessed at www.who.int

129 http://whqlibdoc.who.int/hq/1999/WHO_SDE_HSD_99.1.pdf

In 2004 WHO launched its first global strategy on reproductive and sexual health, which was adopted by the 57th World Health Assembly (WHA) in May 2004. The WHO brochure produced for the strategy states,

> "Reproductive and sexual ill-health accounts for 20% of the global burden of ill-health for women, and 14% for men. Five priority aspects of reproductive and sexual health are targeted in the strategy: improving antenatal, delivery, postpartum and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections, including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promoting sexual health."[130]

Indigenous Declarations

Indigenous declarations tend to highlight health in general terms rather than expressly laying out each area of health that needs to be addressed. The Proposed American Declaration on the Rights of Indigenous Peoples[131], under Article XII, focuses on traditional health as needing protection, but does mention the obligation of states to ensure that Indigenous Peoples enjoy a good status of health. Reproductive health itself is not mentioned.

In critiquing the Beijing Draft Platform for Action, Indigenous women responded with a Declaration of Indigenous Women. Importantly, the Declaration vividly draws attention to the role of dominant paradigms of health and education in the demise of Indigenous Peoples. In fact the participants noted the link between the prevailing orientation of these systems and ethnocide[132]. Whilst acknowledging that there is great inequity in access to health and education, they are however concerned that there is no focus on the role of those institutions itself in undermining the cultural diversity of Indigenous Peoples. At (26) the participants demand:

> "That the governments and international community implement health policies which guarantee accessible, appropriate, affordable, and quality services for Indigenous Peoples and which respect and promote the reproductive health of Indigenous women. That budget allocations to health and other social services be increased to at least twenty percent of the national budget and that a significant amount of this goes to Indigenous Peoples [sic] communities."

Calls were made to stop violence against Indigenous women. These included:

> "**30**. That the United Nations create the necessary mechanisms to monitor the Indigenous Peoples situation especially those facing the threat of extinction and human rights violations and to stop these ethnocidal and genocidal practices.
> **31.** Call on all the Media and Communication Systems to realise that Indigenous women refuse to continue to be treated and considered as exotic, decorative, sexual objects, or study-objects, but instead to be recognised as human beings with their own thinking and feeling capabilities and abilities for personal development; spiritually, intellectually, and materially.
> **32.** Demand for an investigation of the reported cases of sexual slavery and the rape of Indigenous women by the military men happening in areas of armed conflict, such as those within Karen territories in Burma, Chittagong Hill Tracts in Bangladesh, etc. The perpetrators should be persecuted and the survivors be provided justice and rehabilitation and services.
> **33.** Demand for an investigation of the forcible mass sterilisation and anti-fertility programmes done among Indigenous women. Identify which international and national agencies are responsible for these and make them accountable."

Thus a broader view of reproductive and sexual health than that taken by Western Declarations becomes obvious. While not stating reproductive health in these articles, there is a clear link between reproductive and sexual health and the overt impacts of colonisation. For instance (31) raises issues of sexual commodification; this issue is placed alongside demands for an investigation into forced mass sterilisation and anti-fertility programmes enforced among Indigenous women.

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130 WHO (2004). "Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets," World Health Organisation, Geneva Department of Reproductive Health and Research including UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, WHO website, accessed on 26 June 2006, http://www.who.int/reproductive-health/strategy.htm

131 Inter American Commission on Human Rights

132 http://www.ipcb.org/resolutions/htmls/dec_beijing.html

Interviews With Indigenous Scholars And Providers

Two interviews[133] were completed with Indigenous people who are experts in the field of sexual and reproductive health. The first interview was conducted with two Inuit (Nunavut) sexual and reproductive health service providers. The second interview was with a Native American senior researcher who is an enrolled member of the Choctaw Nation. Two questions were asked of the interviewees:

1. In what way is sexual and reproductive health service provision limited?
2. As Indigenous Peoples, in what ways do we deal with sexual and reproductive health?

1. In What Way Is Sexual And Reproductive Health Service Provision Limited?

THE FIRST TWO INTERVIEWEES PRESENTED THEIR INTERVIEW AS DISCUSSION POINTS:

- Limited understanding of Inuit values, culture, ways, history and who we are today;
- National offices and the public don't understand that we don't live in igloos anymore – we are at risk of diseases such as HIV and yet Inuit communities do not have proper access to education/information/resources and awareness;
- Elders are the people we learn from and yet Elders are in the dark when it comes to discussions about HIV and sexual health – they are not included in these discussions – they do not have the language and the vocabulary to talk about sexual health (there are no words to describe what we understand as sexual health);
- Generations of people lived through the residential experience and the intergenerational impacts of residential schools – people are trying to heal/lots of healing going on;
- Sexual health is complicated by abuse people experienced in residential schools – makes it difficult to talk about;
- Inuit are living in two worlds – confusion about who they are – holding on to traditional ways and culture while surviving in wage-earning economies;
- Often other health and social issues take precedence over sexual health and HIV (despite very high rates of STIs and teen pregnancies and growing drug use such as crack cocaine and crystal meth);
- Sexual health work often provided by non-Inuit therefore there is cultural / experiential divide;
- Limited resources in Inuit communities – people and money;
- Parents generation – people didn't talk about sex – people got married, had sex, had families – it was part of life but wasn't talked about – this is a new thing talking about sex;
- There are words for anatomy and sex (heterosexual intercourse) but what about homosexuality, relationships, communication, respect, STIs, maternal health, sexual power and dominance, etc. (all of the things that we understand as part of sexual health)?;
- Now, we have to talk about it because of diseases;
- Traditionally, Inuit lived in family camps – there wasn't the threat of diseases from outside – this has been a growing phenomenon in Inuit communities;
- Often, non-Inuit impose their way of conceptualising and addressing sexual health issues that don't necessarily work for Inuit;
- We have to step back and talk with Elders and youth and other community members about how we are going to approach sexual and reproductive health issues;
- It is important to include Elders so that they understand the facts and so they can continue to be the educators;
- Traditional medicines and healing ways are being/have been lost.

THE SECOND INTERVIEWEE ANSWERED THE INTERVIEW QUESTIONS SEQUENTIALLY.

Origin stories and connections

> *The first thing that came to my mind was the split between mind, body, and spirit, and that western constructions of sexuality and sexual health doesn't take account of creation stories, and our origin stories, and the connection between sexuality and how Creator gave each of us original instructions to live and conduct our lives. It's not connected to those original instructions. So what we have is this split, the split up body part, you know we talk about penis's and condoms, and without connecting it to compassion and love and belonging and connecting, and all of these other values I think we as Indigenous Peoples have. So I think that's a huge piece and also the spiritual piece, and I don't mean a Christianised spiritual piece but one that kind of recognises the beauty in all things and how we connect with one another in the world. So it's bigger than sex actually, sexuality is. It's bigger than gender…*

133 Interviews were completed in Toronto, Canada in August 2006

Disease/deficit model/colonisation/trauma

I don't know how it is in New Zealand but in the United States the focus is so much on a pathology model, you know that we have to prevent disease, it's a disease model. It's not focusing on our strengths and building on healthy expressions of sexuality and gender and relationships. So it's really deficit focused, you know, how do we get individuals to change their behaviours. The other piece is, for Indigenous people I think that a huge problem is, none of our policies and practices in a Western way addresses historical trauma or the impact of colonisation on sexuality and sexual expression and gender and gender identity.

Loss of Traditional stories/colonisation/trauma

For us, the boarding school trauma's here were huge, and when you're separated from your family and your relations, you're separated from the stories, you're separated from traditional stories that were quite often humorous that helps you understand ways of relating sexually, how we take care of one another. An example that is in the South West - they have a lot of coyotes; coyote is a trickster figure. If you listen to the old coyote stories, coyote was very much a sexual being. It's about fertility, it's about life, it's about birthing future generations, there's all of these great stories. Some of them are really humorous, you know, coyote is transgendered. Coyote changes genders all the time, he's like Bugs Bunny, he puts on dresses, he goes and tries to get Fox. Or he takes his penis off and he sends it as a gift for somebody. So there is these great stories out there. But you know, kids today who were raised by parents who were raised by parents who were at boarding school quite often don't have access to those kinds of stories because it makes sex playful, it teaches norms and values around how we relate to each other. It's not pathologised, it's not shameful. It's part of life, it's part of the natural way of cycle. So that part of it, historical trauma, is really missing I think from understanding and contextualising how we may not be yet necessarily healthy in our sexual ways of relating in some ways now.

I guess as an example of that, as a researcher I go out and I do research in the community and we do HIV prevention research. When I first started, and I met with a group of community members, and they said 'We can't talk about sex.' And so I said, Why not?' 'Because that's not part of our culture?' And I said, 'Isn't it? Are we sure of that?' Maybe it's not a part of our colonial trauma response culture to talk about it. But I said, 'At what point did this not become a part of our culture?' It was funny and everybody looked around and they said, 'What do you mean?' I said, 'When did we stop talking about sex?' No-one could put a timetable to it. So we started talking about missionaries and the boarding schools and Christianisation, and how a lot of that shifted attitudes in a lot of our communities around sexual health and reproductive health, even women's bodies. We have 'women's moon time,' talking about reproductive health, women's moon time is what we call it when women menstruate. A lot of different traditions talk about women being very powerful at that time. For that reason women don't participate in certain ceremonial activities for various reasons, that's what we have been told. There used to be certain ceremonies, and there still are in some tribes, for women when they are on their moon. Somehow that got to be turned into that women are dirty or they're unclean, as opposed to they were very powerful at that time and that we have this special role because we are so connected to the moon during that time, and to the life force, you know, the ability to birth. So those were the kind of things you know through colonisation, they get twisted, they get turned around. Then we internalise it, we become psychologically colonised, and our bodies become colonised. Even when we don't think our bodies are being colonised, we're being colonised. I think we buy into that. So those are some of the things that come to my mind about reproductive health and sexual health. And for women in particular, in the States we have very few women who really get good women's reproductive care. They're afraid to go to the doctor because, well, up until the 1970's the Indian Health Service finally acknowledged that they had been sterilising women without proper consent. So you just hear these horror stories all the time.

My mom was one of those ladies, when she gave birth to me, the doctor, she always thought he was racist to begin with and didn't really trust him but you know, you don't say anything, right? He had cut through her uterine wall I guess when he had done the DNC after I was born, sent her home, and she hemorrhaged. I was just a couple of days old and my Dad rushed back to the hospital with her and the doctor took her into emergency care and then, the same doctor, cut through her uterine wall. She died three times that night. And they came out and they told my dad that she wasn't going to make it. My dad said 'what do you mean she's not going to make it?' 'We had to give her a complete blood transfusion and we've lost her a couple of times on the table, it's not good.' And here he is with a couple of days old baby at the hospital. He said he got down on his knees and he prayed right there in the hospital and asked the Creator to just let her live to see me grow up.

And she was considered the miracle lady. She lived. She lived through that but she couldn't have children anymore because he took out her uterus and took everything out.

When they tried to sue and investigate it none of the doctors or nurses would back him up. This was a regular hospital, it wasn't an Indian Health Hospital but my mom felt it was because she was native and he just didn't care. You hear those kinds of stories.

So women tend to not get help for the intervention and again we haven't integrated a lot of our traditional practices. Some tribes still do, they still have their puberty rights for young women and they still have their coming of age ceremonies for the women. But a lot of the youth now are growing up in the cities and they're not having access to those kinds of things, at least not as often as they're used to. That's a major piece. These young women in particular who are growing up and having experienced a lot of trauma themselves too, part of colonisation is for us to think that we can't have boundaries over our own bodies, because they stripped us of our lands and that's a boundary, and they've stripped us of all these things, and stripping us of our sense of our own body as well. So that's I think a major issue for reproductive health is for women, and men, especially takataapui or two-spirit men who also have, at least here in the States, a lot of trauma. That's huge, that lack of self-determination.

I think the hardest thing is when we go back home, and even our men and women who have internalised some of these standards, like women being clean during their moon time, and the way it gets played out in our communities. It's almost like, I was just talking to Sharon Day yesterday and we were saying we need to go back to the origin stories. You almost have to go back to them because it's in those stories quite often that, are all these stories about how people relate to each other. How we belong to one another. How we are to care for one another. If you think about it that's what sexuality is, and that's what reproductive health is, it's carrying on, for us reproductive health, and I know this is probably similar for you guys, having children is a huge issue in our communities… reproductive health is a critical issue for both men and women.

2. As Indigenous Peoples, In What Ways Do We Deal With Sexual And Reproductive Health?

Decolonising ourselves and creating a critical consciousness

I think part of it, to connect to the healing from historical trauma piece, is beginning to decolonise our sexual and reproductive health and thinking about ways that we challenge our own internalised psychological colonised self. How we've colonised ourselves. Let me reframe that because that makes it sound like we're responsible for our colonisation. How we've internalised it and I think challenging it, like these assumptions that I think we call cultural are in fact sometimes for us colonial trauma responses. They have elements of cultural, right, the traditions, residual pieces of traditional values are in there and that's why we connect to it. Things like, 'we don't talk about sex' that comment at the HIV community group mentioned earlier, and I said 'When did that stop happening?' Was, you know, my own little challenge to say well, at what point did part of this become part of our cultural value because there was a time we probably talked about it because it's in a lot of our creation stories, it's in our trickster stories, so why are we not talking about it now? What's that about?
So part of it is creating a critical consciousness I guess around our sexual and reproductive health. Even things that we think are cultural, to begin to look at that and ways to make sure that we've even decolonised things that we think are cultural. It's like peeling away the layers of the onion to keep, you know, getting back to some of those original instructions, those original sources. And it's not that it's going to look, I mean of course it will look different today than it did 500 years ago, but to get back to that original essence I guess more than the instructions is kind of key.

Part of the process is retrieving our stories, prayer and ceremonies, and maybe there is a need for new stories

I think that's part of it. You know, talking to a lot of the elders, I think a lot of people have a lot more knowledge than sometimes they even realise. I think the other way is to prayer and to ceremony. At least we believe, well I believe that to prayer and ceremony as long as you have the water, the elements, the trees, and your fire, and all of those elements in place, and the sky, the earth, you should be able to, you'll feel able to be connected to whatever the instructions are that you're supposed to be connected to. So I think that there's ways to have those ancestors speak to us in the here and now to help us figure out healthy responses and new stories. You know, maybe we need new stories that need to emerge now with HIV. Maybe we need new stories that emerge now with reproductive health. Maybe we need to talk to the grandmas, I mean we have ancient

medicines and teas and things for birth control, for dealing with menstrual cramps, for dealing with a lot of things. But we don't necessarily have tools for modern diseases that were not around 100 years ago so how do integrate those traditional pieces with these kind of new Western diseases that we, you know, that our elders didn't have any knowledge of. I think a lot of our sexual and reproductive health issues, so much of it is tied to trauma, and historical trauma here, that I think part of it is decolonising ourselves through other things so it's healthier environments, decolonising everything will effect ultimately our reproductive and sexual health. I kind of feel like those things are linked so it's not just a situation where need to focus just on this little piece of the puzzle over here to the exclusion of the other pieces. You know, we save the rivers, that helps the waters, that helps the mother who's pregnant, who just gave birth, who's now breastfeeding, and now that milk is now being passed to the child. So you know all these things are connected.

Indigenous research that is needed

The one thing I haven't seen any research on, and I was thinking about this, you know just informally I've talked to a lot of people, talking about women's reproductive health. I think I'd like to see more discussion about native women's reproductive health because I think there's a lot more reproductive health problems in this generation than they were maybe in previous generations and I'm wondering what that may be about. I've informally been doing my old little non-representative poll, I talk to women and a lot of women can't get pregnant now or have a young one. I couldn't, I had endometriosis and so things like endometriosis and cystic ovaries and fibroids, all of these problems and I'm talking to more and more native women and I'm finding out that a whole slew of us have. And I'm wondering whether this is about second and third generation exposures to environmental toxins that have disproportionately affected us.

Our population rate is still going up thankfully but that's only because those that are getting pregnant are having lots of children. But then I wonder if it's almost like, when I think about alcohol research, you've got a high group of abstainers and then you've got another group that are high drinkers. But no-ones really looked at infertility among native women. I think this is more of an issue.

We have kinship systems in place

I think there is our kinship system, there is adoption practices, there is things we can do to have a family where you don't have to have your own biological children. I think a lot of that has been interrupted. Certainly I know that that was more common long ago but you don't see it as strongly in the United States. I mean grandparents intervene when they have to but that's different than having a value for, I have to say it's still different from Western models though. You know if you're a couple who's unable to conceive, it's still reasonable and you're not looked down upon, you're not thought of as less than if you have an adopted child in native communities. It's like oh great, I mean it's a big celebration for everybody.

But I think people having so many multiple burdens it's eroded some of these traditional kinship systems. Where you have informal care but some of it now is more under stress as opposed to having the ceremonies to transfer the connection and the child-rearing of a new child. It's more like when there's a crisis and you have to quickly step in but with no ceremony, no ritual, no connection to embracing something healthy, I'm just thinking aloud, it just seems that way. Yeah, I don't know what your traditions were like in terms of how people traditionally dealt with infertility but I've talked to medicine men and medicine women who claim that they have special plants and things like that to reverse things for some couples, and help people, and I do believe that is out there but it is dependent on who you know and how connected you are to those traditional communities to get access to that…

Two-Spirit / Takataapui whanau

I have a child. You know it's interesting, I'll share with you our struggle because we talked about having co-partnering or having a known donor. It was native. The main reason why we ended up not doing that wasn't because, I was really clear I wanted a native child. I feel very strongly that we needed to continue bringing native children into this world. My partners not native, and I tried and I couldn't carry so finally what we decided was try with my non-native partner. But in the United States we have something called the Indian Child Welfare Act, which ironically I'm completely for because it's of course the non-adoption of Indian kids to non-Indian people. But the problem was that if we went with a known-native donor, that when my partner gave birth to the baby, we'd have to get the fathers release for the child and to do that we would have to get the tribes permission. I know of one instance where the tribe intervened and wouldn't allow the child to be adopted. So, on the one hand it's a policy that's in place to protect Indigenous people but it ends up being a policy for two-

spirit people that's very complex and if they want to not ever sign certain papers or one of the parents is willing not to have legal status with the child, and you know, being a lesbian couple I was not comfortable with not having legal status. So if we were somewhere and my partner got injured and I got injured and we ended up in hospital and I was the only person awake, if I didn't have legal status, that meant that they would've contacted the tribe and the child could've been taken from me or they would've called my partners family and I'd have no say. It was kind of forced to not have a known donor, which is complicated, right, because in native communities you want to know who your relations are and who your line is. Yeah, I know especially for Maori kids your genealogy is really critical. So for our child we knew that she's, her ancestors were Alaska native and now we're working to get her connected to her relatives. And my Choktaw relatives embrace her. She's going to know more native cultures than anyone else I know.

ANALYSIS

PART TWO

A History Of Fertility And Maori[134]

This section is an analysis of theory and history that shaped western views of sexual and reproductive health and impacted on Indigenous Peoples. The sexual and reproductive health area has a history that at times has conflicted with the needs and aspirations of Maori and Indigenous Peoples. This section examines some of that history, a history that regarded 'the other' as 'the unfit'. 'Unfit' populations could then be a focus of social control and fertility control.

Part I: Eugenics Definitions And Theory

Defining The Term Eugenics

This section will look at the range of definitions being used by writers of the term eugenics. In the next section an exploration is made of the theories that underpin eugenics. Eugenics is not a new idea and it is not a simple idea, rather as will be seen, eugenics draws on many older theories which have endured for several centuries.

In some instances writers are only discussing eugenics as controlled breeding: The Concise Oxford dictionary says eugenics is "the science of using controlled breeding to increase the occurrence of desirable heritable characteristics in a population." This is quite a narrow definition and only talks about 'desirable' characteristics. Others make a clear distinction between negative eugenics being 'elimination of defective genes' and positive eugenics which "has invited a great deal of idealistic support with visions of improving attributes such as intelligence and personality" (Campbell et al 1997:66). So eugenics can be about improving breeding stock (genes) or it can be about eliminating weaker or lesser stock (genes).

Elof Axel Carlson whose book "The Unfit: History of A Bad Idea" tracks some of the history and development of eugenics ideas. He says

> "Although the term eugenics has suffered many definitions and its use today is pejorative, the underlying theme of differential reproduction and its consequences is a valid biological concern. All human reproduction has eugenic consequences in this basic sense of the term." (2001:390)

Others including New Zealand and Australian writers have been clear that eugenics is not just about the genetically unfit but also the socially unfit. The groups most commonly targeted have been the poor, immigrants, physically and mentally disabled, ethnic groupings, Indigenous, women, children, gay, lesbian, transgender and others. Each of these groups has produced extensive literature about how they have been defined as unfit and the marginalisation that has occurred as a consequence. The genetically unfit and the socially unfit were sometimes deemed as being the same and sometimes they have been separated. In the past, biological theorists thought that prostitution or criminality was hereditary and could be anticipated by careful study of physical features. (See the writings of Cesare Lombroso)

In an interview with Dr Paul Reynolds, a Maori analyst of biotechnologies, he critiqued more broadly eugenics as it is located culturally within a Western scientific paradigm:

> "Put simply, eugenics is any measure that has an aim of "eliminating difference / abnormality," has an aim of "standardising," and/or aims to "improve" something. In each one of these areas a subjective judgement is made by someone(s) to determine what is "different," "abnormal," "standard," or needs "improvement." This type of reductionist thinking gives rise to simplistic notions of "good genes / bad genes." This is what some critics call "genetic essentialism" which puts great stock in the individual and resonates with an ideology of possessive individualism."

Aboriginal lawyer Robynne Quiggin spoke about eugenics as it has impacted through history as actions, policies and laws that affected her people. She defined eugenics as:

> "The methods used to discourage reproduction include sterilisation, contraception, institutionalisation, forced relocation and migration policies and laws. It was believed that by encouraging desirable traits and discouraging undesirable traits, a more fully functioning society could be created. The kinds of traits that were considered desirable were heavily influenced by cultural assumptions."

134 This section is derived from a 2004 scoping report written by Dr Cherryl Smith for the International Research Institute for Maori and Indigenous Education (IRI), funded by Nga Pae o te Maramatanga, University of Auckland.

It's important to note that while eugenics has achieved a mainstream academic literature, it has also fuelled more extremist groups. In New Zealand, the National Front founded in 1989 describes itself as 'the front line of European colonists' and the organisation is anti- immigration and pro-white policies. They reject immigrants or refugees who are not ethnically and culturally European. They have been reportedly associated with attacks on marae and have been in several protests where Maori have opposed them. The current leader has been convicted of attempted arson on a marae. Hate groups based on white supremacy and others see eugenics as the main ideal in society. One such website www.stormfront.org features specific mention of Maori as an enemy. Quoting from the New Zealand National Front's policy document:

> "We value Western Civilisation as the unique creation of the European folk, and recognise New Zealand as a cultural and demographic outpost of that Civilisation. New Zealand is not part of Asia or of Polynesia, but by virtue of our pioneering race, is a product of the European heritage. That heritage is the basis of our nation's destiny."[135]

The Pioneer fund in the U.S is well known as a key proponent of negative eugenics and the need for social elimination of undesirables. The fund supports research of around $5m U.S per year. The website Future Generations www.eugenics.net is supported by the Pioneer Fund.

Government support for eugenics has also been strong in some countries, for example, in Singapore's Lee Kwan Yew was instrumental in introducing laws offering women with low education financial incentives to have abortions if they had no more than two children. China's one child family policy has been in place for over thirty years.

The Strands Of Scientific Theory That Make Up Eugenics

Eugenics theories, ideas and philosophies have been around for a number of centuries. The origins of eugenics go back to the idea of 'breeding good stock' and were found in Roman, Greek, Spartan and other cultures. The development of eugenics as a science however can be tracked back to Charles Darwin and in particular Francis Galton. It was the English statistician Francis J. Galton who invented the term eugenics in 1883 from Greek roots meaning "well born." He believed that promoting marriage among those with 'superior' traits would improve the human species over time. He called this "positive" eugenics.

Elof Axel Carson in his book, "The Unfit: History of a Bad Idea" says that there are some common myths involved with the eugenics movement. One such myth is that the movement was driven by conservative elites who believed that the lower classes were innately unfit:

> "Their predecessors cannot be classified in such simple terms. It is indeed embarrassing to see many strange bedfellows in the development of the idea of unfit people, and it should give us pause if we believe that the Holocaust could have been predicted from its earliest roots." (P5)

There are a number of strands to the theories that underpin eugenics. The following are some of the cornerstones that have provided legitimacy to eugenics rationales:

Race Theories

The development of race theories occurred with exploration and colonisation from Europe. As the richness and diversity of cultures were 'discovered' ideas were developed about how to describe and explain the existence of others. Ideas about cultural evolution developed - ideas of who was civilised and who was not, ideas about the barbaric other and ideas about the civilising influence of the Empire. Science also began to challenge religion in Europe. According to scientific theory peoples could be categorised. The development of categories of peoples and racial typologies was first begun with Linnaeus who classified people into four categories: Europeans, American Indians, Asiatics and Africans as well as a category called Monstrosus or monstrous forms. (McConnochie et al 1988). The Great Chain of Being was another idea that argued that all life forms were connected and had evolved from simple life to complex life forms or more highly civilised forms. Humans were also ranked on the Chain with the advanced civilisations at the top and the lower down the bottom. From the 1840s literature was reinforcing genetic determinism: that the white man was born to rule and that Blacks were born to be slaves. To this end they argued that the dominance exhibited by Europe and the U.S was natural and inevitable during imperialism and colonisation. Gobineau's work "The Inequality of Human Races" coined the term 'Aryan race'. According to Gobineau, the Aryan race was the developer of all "that was great, noble and fruitful in the works of man on this earth in science, art and civilisation" (cited in

135 http://www.nationalfront.org.nz/policy.php

Carlson P286). Gobineau (1853) also described the human race to be like a body. He called Polynesian, African races "embryo species" (Carlson P287) who are permanently in that stage. He called the Peoples from Oceania: "the most ugly degraded and repulsive specimens of the (black) race".

Social Darwinism

The publication of Origin of the Species supported the belief of natural selection and survival of the fittest. Charles Darwin argued that there is a natural hierarchical order to all species and humans. It was Herbert Spenser that developed the idea of Social Darwinism and before him Hobbes and Mathus. They argued that societies were evolving and that it was natural that the fittest would survive. Currently those opposed to state welfare or welfare-ism believe that welfare dependency is a condition of weakness, laziness, lack of motivation, criminality, avoidance and so on. These beliefs were also tied into economic theory. Beliefs in unrestrained competition in society can be tracked back to the 19th Century. Hobbes argued that it was a duty or a natural right that those who worked the land should have it and as such provided rationales for dispossession of Indigenous Peoples lands, with the view that they are not being industrious and using it properly.

Degeneracy Theories

Eugenics ideas, as already stated, have derived from a number of ideas about the labelling of who is 'unfit'. In the 1700's with the publication of the book "Onania or the Heinous Sin of Self Pollution and All Its Frightful Consequences in Both Sexes," it was argued that masturbation was a form of self-abuse that caused degeneracy in a person and their descendants. By the middle of the 1770s this was picked up as a medical problem and masturbation was a theme of medical school teaching until the end of the 19th Century. Degeneracy theory argued that environmental influences might cause damage to heredity – which could result in insanity, perversion, mentally and physically disabled children. Environmental influences that could cause weaker stock were cultural reasons, masturbation, prostitution, poverty, crime, personal failings, climate, physical features and so on. This led to a focus on sterilisation of male prisoners in some prisons throughout the U.S at the turn of the century. The first eugenic sterilisation law was passed in Indiana in the U.S in 1907 to sterilise 'degenerates". The most famous study done and quoted in many countries including New Zealand was the study by the sociologist Richard Dugdale in 1877 on the Jukes family. The study tracked the intergenerational incidence of crime and prostitution through several generations of one family. (The Jukes study is further elaborated on, see pages 59/60 of this report)
The inheritance of acquired (environmental) characters was challenged in the 1880s by August Weismann, whose theory of the germ plasm convinced most scientists that changes in body tissue (the soma) had little or no effect on reproductive tissue (the germ plasm). At the beginning of the 20th Century, Weismann's views were absorbed by degeneracy theorists who embraced negative eugenics as their favoured model.
Within New Zealand degeneracy theories were highly influential in mental health institutions and prisons as will be shown later in the report.

Genetic Determinism

Genetic determinism is the idea that our genes determine who we are, how we look, what we will achieve, and our physical, emotional and behavioural characteristics. Genetic determinism is the scientific basis of eugenics. Writers vary in their views around how much genes determine physical or biological expression and also social expression. Stephen Jay Gould's book is probably the best known critique of genetic determinism. How much do genes predict behaviour is a fundamental point of discussion. Currently there are searches for a number of genes among targeted populations such as the search for a 'gay' gene, which will be discussed later. The range of strands to eugenics, which may identify ideas of breeding better stock or reducing numbers of undesirables, has meant that eugenics has been an idea that has appealed to many groups, conservative, liberal, left wing, feminist, religious.

Part II: New Zealand And Eugenics

> "It has been rightly decided that this should not only be a white mans country but as completely British as possible. We ought to make every effort to keep the stock sturdy and strong as well as racially pure. The Pioneers were for the most part an ideal stock for a new off shoot of the Mother Country. The Great War revealed that from their loins have sprung some of the finest men the world has ever seen, not only in physical strength but in character and spirit."[136]

136 Commission of the Mental Defectives and Sexual Offenders final report P87

In New Zealand the eugenics movement developed in the earlier part of the 20th Century and was taken up by prominent doctors, birth control advocates, academics and politicians. In a Radio NZ programme[137] on eugenics, it was noted that many people in New Zealand would be surprised to know that within New Zealand eugenics theory held sway at all. But for several decades a eugenics movement existed and eugenics ideals were widely supported from the turn of the century up until the discrediting of the term by the rise of Nazi eugenics in the 1930s. (Fleming P 1981, Stace H 2000)

Hilary Stace a historian who has written articles on Eugenics in New Zealand, says eugenics was a widespread ideology:

> "Plunket, health camps, compulsory military training, youth hostels, the Scout movement, children's homes, the family benefit, large maternity hospitals, even milk in schools had some eugenic reasoning behind them. Eugenics appealed to a large range of people across the political spectrum - from conservatives who sought to limit the fertility of the 'unfit' to the advocates of free love and sexual selection. Only when the birth rate started to rise after the war did the voices quieten."

Maori, like Indigenous Peoples in colonised lands who suffered colonisation, were cast as the 'unfit'. The specific ways in which Maori were seen as unfit can be traced through many ways, including the labelling and classifying as primitive, as a lower social order, as physically and mentally less able, as socially deficient and uncivilised. One example was the way in which Maori (and Indigenous) were seen as weaker species when introduced diseases such as measles, chickenpox, T.B took a huge toll on the population.

The literature in New Zealand on eugenics is very small. The most substantial written analysis of eugenics in New Zealand was an M.A Thesis by Philip Fleming at Massey University in history. Fleming's work was completed as early as 1981 - long before the widespread awareness of genetic technologies and before neo-liberal policies advanced rapidly from 1984. He made this comment in the foreword:

> "In a time when genetic engineering is becoming a disturbing reality, when the welfare state is under threat and when the rights of the handicapped are attracting widespread attention, these issues (eugenics) are still worthy of discussion and debate." (P7)

Fleming's work traces the history of the New Zealand Eugenics Education Society – formed in Dunedin and set up only a few years after its parent body in London. The Society only lasted a few years but there was interest from a wide range of groups.

> "Sir Truby King was one of the more high profile advocates of eugenics. King believed the body was a closed system with a limited amount of energy. The inappropriate education of girls, in anything other than domestic skills, used up their energy and could make them unable to breed or breastfeed. From his observations as Superintendent of Seacliff Asylum near Dunedin he believed mental degeneration was caused by poor mothering. If only women could be taught the 'science' of mothering the racial decline of the Empire could be arrested, and there would be fit soldiers when the inevitable war came." (P21)

Sir Truby King was the founder of the Plunket Society, which began in 1907 and was to create a childcare movement throughout the country. Founded on King's strict regimes for mothers and babies, he and Plunket advocated discipline for babies from birth. They dictated that babies needed to be trained, have four hour feeds, not be allowed feeding at night, and toilet training was to begin early. Indulging a child by cuddling or showing affection was frowned upon. The Plunket movement's promotion of positive eugenics did not appeal to Maori and there was little involvement with Maori until the 1990s. The non-involvement is noted in Plunket's own history – no doubt the reasons for this are many and would need further research.

Following World War One concerns were being expressed about the rise in 'feeble mindedness' with the return of soldiers and also fears were voiced about the quality of immigrants coming into the country. Both these issues contributed to fears of a rising tide of bad breeding. Many high profile people of the time blamed heredity and bad breeding for 'social ills' and they were vocal in their calls for sterilisation, segregation and restriction into colonies of particular classes.

137 8 August 2004 Ideas Progamme, National Radio, Presenter Chris Laidlaw, producer Melanie Thornton

Although legislation was never passed to legalise the sterilisation of certain segments of the population there was widespread concern that degeneracy would see the 'fit' population being over run by degeneracy if some sanctions were not imposed. In 1904 a publication called "Fertility of the Unfit" was released in a New Zealand edition written by Dr William Chapple. Chapple, a New Zealander by birth, was the Liberal MP for Stirlingshire in England. His book advocated sterilisation of the unfit and sold quite well in New Zealand. In England debates had already begun over legislation that proposed the sterilisation of the 'mentally defective' in the Mental Deficiency Bill. Chapple was one of the advocates for the Bill, arguing in Parliament:

> "I have gone into a home and heard the screeching, half-barking sound of an idiot tethered in the backyard like a dog, with the pathetic, grief stricken mother doing all she could to hide it. Do you mean to say it would not be a kindness to go to the mother and say, 'we have a magnificent institution; we will take the child and protect it'?" (cited in Thompson M 1989: 41)

While Maori were not included overtly in discussions about eugenics there were deep concerns about the need to improve 'the national stock'. The national stock as has already been said was clearly British in origin. Numbers of Maori were being made wards of the state and being placed into mental homes and borstals but unless the personal records can be viewed there is little evidence of them at this time.

In the 1920s concerns began to grow about the number of "mental defectives becoming a charge upon the state" and also "the alarming increase in their numbers through the uncontrolled fecundity of this class." These concerns arose partly from returning World War One soldiers who were suffering post traumatic stress disorder but were considered mentally defective. It was felt that the male stock had been weakened.

In the 1920's it was decided to investigate the possibility of sterilisation of those committing sexual offences. Initially, this was proposed by the North Canterbury Hospital Board who set up a Committee to conduct their own inquiry. Others also approached Maui Pomare, the Minister of Health and he set up the Committee.

The name given to the inquiry was the Commission of Inquiry into Mental Defectives and Sexual Offenders 1924. Members of the Committee of Inquiry were appointed by Sir Maui Pomare, Minister of Health. They consisted of:

Chair WH Triggs
Sir Truby King
Sir Donald McGavin
Ada Paterson
Chas E Matthews
J Beck

Of the 92 submissions received by the Committee, the majority were high profile doctors, medical officers, health inspectors, inspectors of schools, church representatives, women's organisations, and prison and mental home superintendents. Sir Robert Stout, former Prime Minister, was a eugenicist who applauded the idea of stopping anyone who was mentally defective from breeding, saying "those who are mentally defective should be kept at some state institution and not be allowed to breed". While he noted that the U.S had legislation in place that allowed for the sterilisation of sexual perverts he lamented that "our people are not yet thoroughly alive to the importance of eugenics" (P2). As a judge he linked criminality with feeblemindedness saying that a quarter of those appearing before him in the courts were feeble minded:

> "I think they should also be set apart in a home where they will not be allowed freedom from control, but will be looked after and given such happiness as possible, but be subject to confinement."

Banning marriages of the unfit and certifying people before marriage were suggestions put to the Committee. Many submitters advocated sterilisation. Some submitters pointed to social Darwinism as a reason for negative eugenics and sterilisation:

> "…we have to recognise the inequality of mankind, second, that heredity plays a most important part in the life of our offenders and third that the State has a right to prevent them from breeding." (Stout P4)

Others argued for segregation. A submission made on behalf of the Department of Education noted that there was great alarm expressed at the overwhelming numbers of 'feeble-minded' children and adults who should be prevented from breeding by segregation. The submitter argued that by not acting there would be 'serious racial deterioration'.

Many of the submitters pointed to the increase in numbers of 'defectives', which the superintendent of Auckland Mental Hospital explained as being attributable to the increases in 'humanitarian methods'. He stated that "At the present time the duration of life is increasing, but I do not think that the virility of the race is increasing… At present we are saving a number of people who would have formerly died." Strong arguments emerged for confining the mentally defective into farm colonies. Detailed advice was given on how the colonies should be set up. Castration or 'desexualisation' of sexual offenders was considered by many.

At the time homosexuality was a crime and a number of inmates were clearly imprisoned and counted as 'sexual perverts'. One of the prison doctors testified "we have three types of sexual offences: 'homi-sexualism (sic) rape and exhibitionism" Homosexuality was equated with degeneracy and it was suggest that treatment should consist of outdoor activity and hard labour. It was also clear that homosexuality was considered part of mental defectiveness by submitters:

> "Take the case of Oscar Wilde – a man like that shut up for life would be a loss to the whole world. I would desexualise him and let him loose to a large extent. Take another case of an intelligent man, a lawyer who was mayor of a certain town and who was sentenced to 15 years for homosexuality – if that man had been de-sexualised the country would have been saved the expense of detaining him in gaol for that length of time." (Medical Superintendent of the Auckland Mental Hospital P297)

Degeneracy theories were a keystone belief of many of the mental health workers and doctors who gave submissions. Many considered degeneracy to be rampant:

> "Give the chance to the exceptionally passionate individuals to relieve themselves by availing themselves of the opportunity presented by licensed brothels so that they will not develop possibly on the one hand into the degenerate known as the "Masturbator" or on the other hand into the type who commit rape or who commit indecent assault on children in order to relieve themselves." (Superintendent of Mt Eden Prison P308)

Superintendent of Tokaanu Hospital, Dr James McPherson, spoke on degeneracy. He had studied the subject for nine years. Pointing out the references of judges, magistrates and church authorities who pointed to degeneracy he also quoted Sir Morris Craig "one of the leading alienists" who said that "the time was fast approaching when we must do something because otherwise the wave of degeneracy will swamp us and we will disappear." According to the Doctor the degenerates bred a lot more.

Sir Truby King submitted that in almost all cases where a child was feeble minded it was found that one or other of the parents was feeble minded, therefore it was a matter of heredity. However he pointed out that as a school teacher he was also of the opinion that environment was also important. Education and training the young was emphasised so they would not deteriorate.

Winifred Valentine, a teacher, advocated the building of colonies for mental defectives in the country with the boys and girls being separated. A number of submitters blamed attendance at picture theatres as being a cause of social ills and felt that restrictions should be in place especially for youth.

Reporting to the Minister, the Committee found that:

> "The committee are of the opinion that the unrestricted multiplication of feeble minded members of the community is a most serious menace to the future welfare and happiness of the dominion and it is of the utmost importance that some means of meeting the peril be adopted without delay."

While the committee recognised the influence of the environment and urged the importance of healthy food they clearly stated:

> "…that it has been proved beyond question that if two feeble-minded persons marry, they will most probably produce abundant off spring of whom all may be sub-normal and a large proportion will become a burden on the state." (Report to Minister P13)

The Commission spent time detailing the case of an upstate New York family called the Jukes, a well known study at the time, which claimed to prove hereditary degeneracy. Compiled by R L Dugdale, he traced intergenerational family patterns through the Jukes family. Dugdale researched five generations of the Jukes to argue that degeneracy ran through families. Within five

generations of the Jukes family, the majority were prostitutes, criminals and paupers. Of the 540 born into the family over five generations, one fifth were said to be born to parents who were not married, 37 had syphilis, 53 had lived in poor houses, 76 had been imprisoned, and 128 of the women were prostitutes. It was stated that the burden to the taxpayers of New York was over one million U.S dollars. The Jukes study was commonly quoted at the time to show how, if left to themselves, the unfit would breed prolifically and produce more of the same 'degenerates'.

Eugenics Board

The Commission was clear that there were grave concerns about 'the purity of our race' and they moved to recommend the establishment of a Eugenics Board with a skilled psychiatrist, a member of the medical profession and a magistrate.

In the report Dr Theodore Gray (P49) had made suggestions of setting up a government department created to deal with all the feeble minded living outside of institutions. The Commission suggested that this be a Eugenics Board that kept a register of all those who had been discharged from mental hospitals and any feeble minded, epileptic and mentally defective persons, with mandatory reporting from prisons, mental homes, education department and so on. They suggested that the Board should be able to recommend "segregation, supervision or treatment of the different classes."

The register was not only to set up a register of names but to also prevent certain groups from marrying – anyone on the register would be legally prevented from marrying. Parents who allowed sexual relationships would also be prosecuted.

The Commission pointed to the laws already passed in some U.S States that sanctioned sterilisation of the feeble minded, insane and criminal including Dr H Laughlin who wrote on sterilisation in the U.S and how to set up a law. The Commission recommended that the Eugenics Board be given the power to decide if sterilisation or segregation was appropriate for registered individuals on the list. Also they would be able to decide if sterilisation was a necessity before release from an institution.

They also noted the importance of preventing the feeble minded immigrant from entering the country. They emphasised the importance of the 'right' immigrants as the stock had already been weakened by 'the Great War'. Concerns were being expressed that shell-shocked soldiers were weakening society. The report quoted a number of overseas 'experts' on eugenics.

Establishment of farm colonies was also recommended for the feeble minded. It was estimated that at that time at least 1476 people would need to be registered. Theo Gray the Deputy Inspector General of the Mental Hospitals Department proposed the Eugenics Act. Four years later the Mental Defectives Amendment Bill was introduced. Stace says:

> "A Eugenics Board was set up to keep a register of 'mentally defective persons' and two women were among those appointed to it. They were Jean Begg, and Janet Fraser from the Wellington Hospital Board. Janet Fraser was married to future Prime Minister Peter Fraser, ironically a critic of negative eugenics, possibly because of the mental health problems in his own family."

Hilary Stace points out that the recommendation to sterilise the unfit was not followed through:

> "However, there was a level of discomfort in the community over the inquiry's recommendations. Most of the more extreme suggestions, like sterilisation of the 'mentally defective' and banning of marriage with same were dropped from the Mental Defectives Bill of 1928, much to the anger of those like Nina Barrer of the Women's Division of the Farmers' Union."

Appointments Of Maori To Mental Hospital Staff

At the time of the Inquiry it is difficult to get numbers of how many Maori were inside institutions. There are side references, which reveal some of the racism that was prevalent at the time. The Report of the Inspector General 26/3/1926 noted that there were three Maori in the whole country who were on the staff of Mental hospitals. They were employed in the Wellington district. While Maui Pomare was the Minister of Health, the Inspector General requested the figures for Maori working in mental institutions. At Porirua the medical superintendent said in a letter to the Inspector General that:

> "There have been a number of applications from young Maoris for positions as attendants on the staff here but I have refused to consider their applications for the following reasons. …… I told them quite frankly that I did not think it advisable to have Maori attendants for white patients."

He further argued his position by saying that there were only ten Maori male patients there.

In 1952 and 1954 the New Zealand Police investigated cases of 'alleged immoral conduct by children in the Hutt Valley.' The view of the time was that moral standards were falling. As a result a committee was set up and given the title of Special Committee on Moral Delinquency in Children and Adolescents. They were to inquire and report on 'conditions and influences that tend to undermine standards of sexual morality of children and adolescents in NZ…….' (Archives Wellington B309)

Philip Fleming who wrote his Masters thesis on eugenics argued that eugenics in New Zealand was more about social Darwinism. Although legislation never went through to sterilise certain segments of the population there was widespread concern that degeneracy would see the 'fit' population being over run by degeneracy if some sanctions were not imposed. The NZ Eugenics Education Society booklet outlined their views. They argued that a lot of money was being spent on the unfit, that the unfit were prolific breeders, the unfit produced more criminals, prostitutes, insanity, amongst other conditions. This caused a burden on the taxpayer and society and so the State needed to intervene to ensure that fit couples had more children and that unfit couples should not have children. The booklet argues that social control should be achieved through 'sterilisation, segregation and marriage certificates.'

New Zealand historian Hilary Stace has also clearly argued for the need to revive the discussion of eugenics. She argues that many New Zealanders would equate eugenics only with Nazi extermination of Jews, blacks, homosexuals and gypsies and that most would regard eugenics as having died out. But she argues:

> "Eugenics is alive and well today and has everything to do with us. Take fertility issues. What is the purpose of amniocentesis and other pre-natal tests offered routinely to pregnant women, but to abort the foetus if it proves to be 'abnormal'? This is a eugenic decision. Recent controversy in New Zealand surrounds free pre-natal testing and whether easier access to tests will encourage more terminations. In these times of limited resources for health care and education it is a brave parent who decides to continue a pregnancy with a known foetal abnormality. What implications does this have for the disabled in the community?"

Fleming argued in his thesis that there is little evidence to show that eugenics was a populist belief beyond academics, politicians, biologists and so on. However Stace differs in her definition of eugenics saying that eugenics goes beyond a scientific idea and is more entrenched into everyday thinking and rationalisations. She sees eugenics as being very pervasive as an idea and can be recognised in many arenas:

> "Eugenics has been presented in the past as a science and a philosophy. I prefer to label it a mindset. Imagine this scenario. You are a middle class pakeha in early 20th Century New Zealand. There has been much media publicity that the birthrate of your class/type is dropping but the birthrate of other groups is escalating. These 'other' might be from a difference race or socio-economic group, or might appear less intellectually or physically able than you, or less healthy and certainly less 'responsible' than you. They could be a burden on you as a taxpayer or citizen by using scarce state resources. They appear less financially secure, and are maybe unable to earn an income because of unemployment or disability. Their mental state could be a perceived threat to you or your family. You could also have fears that your lifestyle, country or Empire, is at risk from 'land hungry' nations who have rapidly growing populations and there is a threat from them of possible invasion or war. Are your soldiers healthy and fit enough to defend you? Perhaps you worry that war will rob your country of the most virile breeding male stock. Other mothers do not seem to be parenting as well as they should and their children are suffering. Some 'selfish' women might appear to be keener on having a career than children, or want to limit their families because childbirth and childrearing is such hard work. Perhaps academic education is harming the health of many girls so they are unable or unwilling to breed, or perhaps the education they are receiving is not teaching them useful domestic skills. Above all, healthy food and outdoor living are essential to building character, healthy children and responsible adults who will be the healthiest breeders and the saviours of the race. Yet people are not always heeding this message.
> These were some of the eugenic beliefs of New Zealand's past (and would still have many supporters today). Eugenicists[sic] tended to be the educated middle class who were anxious to find solutions to the perceived social and economic problems of society and knew about Darwin." (P2)

Stace says that in New Zealand there were a number of areas such as a falling birthrate, concerns over weakness in the population, and fears about the quality of immigrants. This ideological framework helped to popularise the issue.

Key Figures In New Zealand Eugenics History

The Dictionary of New Zealand Biography database at www.dnzb.govt.nz explicitly mentions the following profiles as high profile New Zealand advocates of eugenics. (The following notes have been abbreviated from the website):

Begg, Jean 1886 - 1971
Welfare worker and administrator, feminist
Jeannie Begg trained as a missionary and went to Samoa where she ran a health clinic. After nine years in Samoa she travelled to the U.S where she studied social work and advocated for women's rights. She became a member of the Eugenics Board, favouring separation of the mentally unfit and arguing that if those with anti-social behaviour were sterilised they could be placed back in communities.

Benham, William Blaxland 1860 - 1950
Zoologist of world renown who was appointed to the University of Otago, on the professorial board of the University of Otago, on the University of New Zealand senate and founder of the Eugenics Education Society.

Field, Arthur Nelson 1882 - 1963
Journalist, writer, political activist, anti-Semite
Worked for the Evening Post, the Taranaki Herald, Poverty Bay Herald and then the Dominion. He was a well known journalist but also wrote his own journal to promote motherhood, eugenics and monetary reform and to attack 'Maori obstructionists'. He was also a member of the Britons, an anti-Semitic group. He wrote and published a number of publications on Jewish conspiracies and left his collection of right wing and fascist publications to the Alexander Turnbull Library.

Fraser, Janet 1883 - 1945
Community leader, married to Peter Fraser
Health, education and welfare issues were to concern her throughout her life and led to a series of official appointments: in December 1926 she was appointed one of the first women Justices of the Peace, in 1927 an associate of the Children's Court, and in 1929 to the newly formed Eugenics Board, whose duties included keeping a register of 'mentally defective persons'. She was also an official visitor to the Porirua Mental Hospital. Fraser was involved in many women's organisations, in particular the League of Mothers, the New Zealand Society for the Protection of Women and Children, the Plunket Society, the Women's Borstal Association of New Zealand, and the New Zealand Federation of University Women. She was also interested in the welfare of Polish and Chinese refugee children.
In 1935 Peter Fraser became Minister of Health in the first Labour Government, but it was Janet who had much of the expertise. She was appointed to a committee of inquiry into abortion, followed by one into maternity services, which spent many months conducting hearings throughout New Zealand. Both committees investigated a wide range of social, economic and health issues. As a result the Government brought in measures to provide financial support for maternity services and child rearing.
The Wellington Children's Health Camp Association made her one of their vice presidents. She commented on employment and welfare policies, housing developments, child health, justice systems and the position of women in the countries she visited; she showed a particular interest in women's work in non-traditional areas and (during the war) their war work. In 1936, she spoke of women in England working in areas such as property management, engineering and architecture. Her talks and interviews had a large audience. The Frasers also enjoyed the theatre and orchestras, and Janet was extremely well read. Her influence may have contributed to the Labour government's many initiatives in arts funding.
As patron of the Te Ropu o te Ora Women's Health League she had been connected with the effort to build a hostel to accommodate Maori visitors to Rotorua; the Janet Fraser Memorial Guest House was opened by Peter Fraser on 30 August 1948. Because of her work for Maori, she was known as 'Te Whaea o te Katoa' (the mother of us all).
Janet Fraser was tall, thin, dark-eyed, dignified and gracious. To her granddaughter, Alice, she was loving but proper - not the sort of grandmother you could hug with floury hands. Her lifelong concern for the poor and disadvantaged and her lively interest in health matters and women's concerns made her an important adviser to her politician husband.
Stace, Hilary. 'Fraser, Janet 1883 - 1945'. *Dictionary of New Zealand Biography*, updated 16 December 2003

Gray, Theodore Grant 1884 - 1964
Psychiatrist, mental health administrator
He graduated in medicine from the University of Aberdeen in 1906. He then spent a short period in general practice before being persuaded to work at Kingseat Asylum, Newmachar. The ordered, regular routine of a self-contained mental hospital suited Gray? This was the first British psychiatric hospital built entirely of villas that segregated patients according to diagnosis,

behaviour, dependency and gender. He was later to foster this system in New Zealand, and to give the name Kingseat to a new hospital at Papakura.
In 1911, having acquired a certificate from the Medico-Psychological Association of Great Britain and Ireland, Gray was recruited by the Mental Hospitals Department in New Zealand. There he served as junior assistant medical officer at Porirua Mental Hospital and senior assistant medical officer at Auckland Mental Hospital. He then worked under Frederic Truby King at Seacliff Mental Hospital, near Dunedin. In 1921 Gray became medical superintendent of Nelson Mental Hospital; he planned to replace it with a villa hospital at Stoke. Truby King, now acting inspector general of mental defectives, considered Gray a promising administrator. He was appointed acting medical superintendent of the Auckland Mental Hospital in 1925 and shortly afterwards deputy inspector general of mental defectives. Gray succeeded King as permanent head of the Mental Hospitals Department in 1927.
In the 1920s Gray was involved in planning changes to services for the intellectually handicapped. He gave evidence to the Committee of Inquiry into Mental Defectives and Sexual Offenders in 1924, and wrote an influential report on an overseas study tour in 1927. His approach was informed by some of the more severe aspects of the eugenicist movement. He proposed separate 'farm colonies' for the intellectually handicapped, statutory registration, psychological screening clinics, and closely regulated sterilisation in certain circumstances. These recommendations were included in the Mental Defectives Amendment Bill 1928, although the more controversial aspects were dropped following vehement parliamentary opposition. Gray subsequently stayed silent about his views on eugenics and the sterilisation of the mentally unfit, and on his chairmanship of the short-lived Eugenics Board.
Gray was appointed a CMG in 1938, and honoured professionally. He was elected a fellow of the Royal Australasian College of Physicians (1946) and president of the New Zealand Branch of the British Medical Association (1947). He served, sometimes *ex officio*, on the Prisons Board and subsequent Parole Board (1929--57), Nurses and Midwives Registration Board (1945--47) and the Medical Council (1948--56).

Lane, William 1861 - 1917
Journalist, socialist, expounded racist views as a newspaper editor.

Satchell, William Arthur 1861 - 1942
Orchardist, writer, stockbroker, novelist, accountant.

Valentine, Winifred Annie 1886 - 1968
Teacher, educationalist.

Family Planning And Negative Eugenics

The history of the Plunket Movement and the Family Planning Association is also linked to eugenics. Pania Ellison, an educator and researcher in Maori Health and Reproductive Wellbeing, noted in her interview that the history of the Family Planning Association in New Zealand had significant links to the eugenics movement.

Helen Smyth who has written a history of the Family Planning movement in New Zealand uses the definition of eugenics to mean "the control of reproduction to produce better offspring"*(*p15), and makes the point that:

> "many of those who lent their support to the birth control movement did so because of their belief in controlled breeding. It was a eugenics society that first offered support to New Zealand's fledgling family planning group" (p15).

Fertility control has always been political. In New Zealand in the 1960s, with Maori urbanisation and the rapid expansion of the Maori population, attention began to be focused on contraception for Maori. Maori were having big families and that was considered a 'problem': as the President of the Family Planning Association pointed out big families were "at the 'wrong end' of the population". The racist overtones evident in concerns over the large families that Maori were having caused tensions between the Family Planning Association (FPA) and Maori communities. In the history of the FPA Maori communities and organisations resisted the messages that saw Maori being told that Maori fertility should be controlled. The FPA targeted Maori families through the 1960s to increase the numbers who were taking contraception.

The introduction of Depo Provera saw a disproportionately high administration of the contraceptive injection to Maori women. Philidda Bunkle and Judith Ackroyd wrote about its administration in 1982 saying:

> "Sometimes it seems that Depo is the new eugenics, preventing the breeding of the socially unfit; handed out in prisons and mental hospitals and abortion clinics and given to Maori twice as often as Pakehas. Depo is not accepted as a contraceptive in Australia but is given to Aboriginal women; it is stringently limited in Britain but prescribed extensively for West Indians; it is approved for Black but not White women in South Africa." (cited in Smyth P122)

The establishment of Te Puawai Tapu in the early 1990's by Irihapeti Ramsden and Paparangi Reid saw the development of a Maori organisations focused on Maori sexual health and wellbeing. Recently a furore arose when Maori Party M.P Tariana Turia gave a speech at the Maori Sexual and Reproductive Health Conference[138]. Saying that she was intolerant of the excessive focus on Maori fertility rates, she argued that all children born should be welcomed:

> "So when Cabinet Ministers sat around tut-tutting the fact that the fertility rate for Maori females aged 13 to 17 years was 26.2 per 1000, more than five times that of non-Maori ... I objected to their analysis of our fertility as a problem."…… "I believe our fertility has been controlled and I don't personally agree with it. We have been brainwashed into believing that having more than two children is wrong."

Turia pointed out that Maori and Pacific women's abortion rates had been higher than those of non-Maori for years and questions had to be asked about why. She also noted that in her lifetime, the average Maori woman has 2.47 children. The average for all NZ women (Maori included) is 1.9 children[139].

Part III: International History Of Eugenics

Chronology Of Events

1744-1829 Jean Baptiste de Lamarck developed a theory of heredity that included the idea that if a person built up strong muscles in their lifetime then they could pass that on in later generations. The giraffe's neck was an example of directed evolution, which over generations had become inheritable.

1839 Samuel George Morton wrote Crania Americana which argued that by looking at the skull size the inferiority of Indians, blacks and women could be proven. *(New Zealand experiments done by ships surgeon)*

1853 Arthur Comte de Gobineau published an essay titled "The Inequality of the Human Races". He saw human history as being about superior races asserting their strength over others. He viewed racial history as a science.

1859 Charles Darwin – Origin of the Species – natural selection began to be applied to the science and ethics of human society.

1860s Gregor Mendel, a monk, spent time breeding plants, observing and noting differences in the generations. He discovered that inheritance was governed by dominant and recessive characters (the word 'gene' was not used until 1909). He wrote up his theories in the 1860s but his work was not publicised in England till the turn of the Century

1865 Gregor Mendel, a Gregorian Monk who grew peas spent years observing and recording distinct characteristics of peas and how subsequent generations were to have these passed on. His paper "Experiments With Plant Hybrids" is regarded as the founding of modern genetics.
Francis Galton – Hereditary Genius.

1876 Cesare Lombroso – Published "Luomo Delinquent" which argued that criminals could be recognised by bodily features or body markings such as tattoos.
Francis Galton – Inquiries Into Human Faculty and Its Development

1880's August Weimann a German biologist who was a microscopist found that the hereditary traits were in the chromosomes. He noted that germ cells control reproduction and somatic cells are body cells and that there was a key difference. This effectively overturned Lamarck's view that what was learnt could be inherited. This key shift meant the introduction of eugenics and the possibility of eliminating the 'unfit' such as the feeble minded, mentally defective and so on. Weismann used the term germ plasm to denote the hereditary material passed from generation to generation and later these would be called gametes.

1895 Alfred Ploez wrote the first book in Germany coining the term 'rassen hygiene' which advocated such measures as withdrawing any support for the poor past childbearing age and warned against medical care of the weak which only allowed the weak to survive and breed.

1895 British Social Darwinist John Haycraft talked about certain diseases as being "racial friends' such as TB, scrofula, leprosy as they attacked only those of a weaker constitution.

1899 Laws were passed in Michigan to prevent marriage of those who were deemed 'idiots', insane or anyone suffering from gonorrhea or syphilis.

138 6 Nov 2004 NZ Herald Turia Says Two Child Families Not Maori Way.

139 Source: Statistics New Zealand.

1905 Birth of Society for Racial Hygiene in Germany – with Ploez, anthropologist Richard Thurnwald, psychiatrist Ernst Rudin and lawyer Anastasius Nordenhelz.

1907 Racial Hygiene Society membership was up to 100. Widespread academic, scientific and medical support for race hygiene.

1907 The first forced sterilisation law in the United States is passed in Indiana. By 1944, 30 States with sterilisation laws had reported a total of more than 40,000 eugenic sterilisations with those sterilised reported as insane or feebleminded. While 1907 - 1964 are considered by many to be the height of forced sterilisations, the numbers of women, predominantly Native American women and other poor women of colour who were sterilised after that period continued to be high.

1931 International Association for Population Science in London.

1932 International Eugenics Conference in New York.

1935 International Congress for Population Science.
The Berlin conference was essentially a continuation of the International Eugenics Conference of 1932, which had elected Prof. Dr. Ernst Rudin, later the author of the Nuremberg race decrees, as its chairman.

1935 Germany had thirty plus Institutes in existence that focused on racial science and racial hygiene.

1938 Nuremberg “Laws for the Protection of the Blood." The entire Nazi training manual on the Nuremberg racial laws consisted of propaganda for the “Law for the Protection of German Blood and German Honor," which banned “mixed marriages" with members of other “races," especially Jews and gypsies.

Race Hygiene

The history of the rise of the Nazi regime in Germany is usually written of as an isolated history but contemporary writers have argued that there were many links between European, U.S and U.K academics and scientists who theorised elimination of the unfit and emphasised genetic studies. These associations continued before and after the war.
The history of Nazi Germany has been one that has continued to be taught through history until today.

Key beliefs that existed within the U.K, Europe and the U.S, Australia and New Zealand at the turn of the century were ideas such as:

- welfare or charity or medical care was misguided
- the weak are breeding faster and the desirable population is diminishing
- charity just prolongs the natural dying out of the weak
- the weak could take over the strong, causing ‘degeneracy’
- degeneracy can be shown by numbers of criminals, poor, and prostitutes, amongst others

(Within all these groups Indigenous Peoples would have been positioned as would immigrant populations)

Other ideas that arose are around how strong stock and weak stock are defined.

Weak	**Strong**
Poor	Military elite
Weak	Political elite
Sick	Intellectual elite
Insane	Usually Nordic

The birth rate of the ‘weak’ was high and the birth rate of the ‘strong’ (or fit) was declining. In Germany the ‘rassen hygiene’ movement rejected birth control. According to Proctor, race hygiene in the 1920s was less about the Jewish question and focused primarily on the declining birth rate and increases in the mentally insane. There was also concern over the fact that feminism and World War One were destroying families. Racial hygienists saw in genetics and eugenics a set of tools that might help solve social problems. Proctor’s book looks at the role of doctors in the development of Nazi racial science and policy. Numerous doctors were theorists, advocates and practitioners of Nazi medicine. Other writers have drawn the links between the psychiatry profession and pointed to its involvement in the sterilisation and extermination programmes in Nazi Germany (Burleigh M 1994, 1991, Weindling P 1989).

Extermination policies rather than sterilisation policies were carried out in Nazi Germany. Medical research carried out in concentration camps included experiments involving:

- Freezing / Hypothermia
- Genetics
- Infectious Diseases
- Interrogation and Torture
- Killing / Genocide
- High Altitude
- Pharmacological
- Sterilisation
- Surgery

The Nordic or Aryan Race was the most important goal of the Nazis. It was the largest part of the over all plan. The blonde haired, blue eyed super men were to be the only race. The Blacks, Hispanics, Jews, Gypsies, homosexuals and anyone else that did not meet the race requirements were to be cleansed from society through genocide. Hitler and the German High Command made a list of rules for fellow Nazis to follow. The rules required all SS before marriage to submit to general testing to insure racial purity. The rules for marriage were unbelievably complex. Thousands of marriages were denied. If the laws for marriage were broken it could mean the death penalty.

Early in power the National Science groups were pushed into research of the race, and experiments commenced. First the party needed propaganda to prove all other races were inferior. Measurements of heads, eyes, nose and blood were required. The vast majority of the early experiments were for propaganda purposes. It was determined Gypsies had different blood and were inclined to criminal behaviour. The same types of findings were made of all races other than Nazi.

After the camps were started, vast genetic experiments were undertaken. The range of the testing was broad and specialised. The two major groups of experiments were first to refine the master race and second to determine the cause of defects.

Dr. Josef Mengele's research on twins and Gypsies exemplifies the quest for the genetic studies. Dr. Mengele was known as the "Angel of Death". He would be at every selection when the new trains would arrive at Auschwitz. After the victims were unloaded off the trains and stripped naked and divided into men, women, and children, he would sort through the thousands of people. Most went straight to the gas chambers and others to hard labour in the camps. The twins, dwarfs, and unique physical specimens were selected to be assigned to the experimental blocks. Some might say that it was an advantage to be killed in the gas chambers than to be the survivors and research subjects for the human experiments.

In the book "Cleansing the Fatherland Nazi Medicine and Racial Hygiene" by Gotz Aly, Chroust Peter, Pross Christian, the argument is made that although the Nuremburg doctors' trials of 1946/47 were supposed to try doctors, in fact many were to profit post war financially and professionally. Shielded by their profession and colleagues they were never called to account. Much of the work was done in the name of public health and extermination was sanctioned of many; the disabled, troubled teenagers, immigrant labour too old to work and the mentally ill were all targets.

Placing The Unfit In Colonies

In England, the 1908 Royal Commission on the Feeble-Minded undertook an extensive survey of possible ways to care for the mentally defective, and was particularly interested in the idea of the colony. Discussion had taken place of putting the unemployed in colonies in the countryside for resettling depopulated land. Also groups of orphans had been sent overseas, including to New Zealand:

> "As these examples suggest, the attraction of the colony was not simply that it provided new institutional solutions to discrete social problems, but also that it was a salve to broader social anxieties about rural depopulation, urban squalor, and racial degeneration."

Although colonies for the sick and handicapped placed greater emphasis on medical therapy, their regimes were still disciplinary in style. The evolution of tuberculosis colonies epitomises this and provides a striking analogy to the shift from

mental asylums to colonies. At the turn of the century tuberculosis had been tackled by confining the infected in sanatoria, thereby containing the spread of the disease and assisting recovery through a healthy environment and rest. The problem with this strategy was that discharged patients often relapsed when they returned to the stress of industrial work in the community.

Population Control

Concerns over how the growing world population should be handled is another area that frequently raises questions of eugenics. Some statistics say that by the year 2050 the world's poorest 50 countries will triple in size to 1.7billion people and in advanced capitalist countries and others with strict policy on birth control, the rates are dropping. "Capitalism is the best contraception" Wattenberg quoted in News week 27/9/04.

The U.N's focus on the battle against population has been criticised for being a 'battle to reduce the non-white' (Liebig G) people in other parts of the world. In the 1930s interest in population science came to the fore prior to the Second World War when the International Congress for Population Science was held which brought together a gathering of several hundred population specialists in Berlin in 1935. What was clear at the gathering was an overt focus on eugenics and population control.

Arguing that there is no change in current population conferences, Gabriele Liebig asserts that the U.N population fund continues the same focus of demonising Third World countries as 'overpopulated' despite their falling birth rates since the 1970s. :

> "Since the 1970s, from 6.1 to 3.9 children per mother, it is claimed that the black, brown, and yellow people there are still far too prolific… Latter day population experts like Stycos put forth their own special "racial criteria": Africans and Chinese are clearly unworthy of possessing technology. For China, "birth control is more important than economic development," Stycos declared in his Stockholm speech. "It would be a catastrophe if every Chinese had a refrigerator."

Quoting Mische she says;

> "The far higher birth rates in most countries of the Third World will mean that in the relatively short period of 30 years, out of each 100 million people on the globe, scarcely 10 to 12 will be white."

Euthanasia

During the Nazi era economic analyses were done also to outline the cost-effectiveness of being mentally and physically unfit. Felix Boesler calculated how many Reichsmarks per person were spent on the care of the mentally ill, deaf-mutes, the blind, and "cripples." Today, the debate over euthanasia and the demand for cost-cutting in medical care have made us familiar with such arguments. With the help of current "discussions" in the mass media, a scale could already be drawn across which some lives could be placed – lives that are "unworthy to be lived," according to public opinion, legal statute, and medical guidelines, because they are judged too expensive to sustain.

Peter Singer, an Australian bioethicist appointed to Princeton University, has been a controversial figure saying that children less than one month old do not have human consciousness and therefore do not have the same rights as others. He has also argued that killing a disabled child is not of equal consequence as killing an adult. Students and staff protested his appointment at Princeton. A utilitarian, he believes that not all people are persons, some are 'non-persons'. In his 1993 book Practical Ethics he says that young children and people who are in a 'persistent vegetative state' can be defined as non-persons. He argues that therefore killing someone in that state can be seen as less wrong. In Practical Ethics he says that it should not be illegal to kill a child that is disabled who is under 28 days old and that neither should it be illegal to kill other non-persons such as disabled aged people.

> "The distinction between "persons" and "non-persons" has led to Singer's prominence within the animal liberation movement. He argues that it is mere "speciesism" (the prejudice that membership in the right species is what earns beings moral consideration) leading us to believe that all human lives are of equal value. Singer wants us to recognise that many non-human animals should be treated with the same respect with which we believe humans should be treated." (Montogmery 1999)

Some consider it a waste of money to keep comatose patients alive. In some countries assessments are made of “Quality adjusted life years” (QALY) criterion, which looks at the costs of expensive treatment, which is weighed up against how much money will be spent on the patient. Elderly patients and the acutely ill therefore have lower ratings for sustaining life.

Euthanasia debates in New Zealand have been highlighted recently with the conviction of a woman Lesley Martin in Whanganui, who tried to kill her mother who was terminally ill. She argued that she was attempting euthanasia. Opponents of the recent Death With Dignity Bill, which was defeated, argued that the state was under-resourcing the health system and that better pain free care of the dying was required, more assistance for families of the dying and good quality medical services should be in place for the terminally ill.

Population Control

The various issues around population control, which has been a focus of the U.N and World Population Conferences has brought a number of issues into focus. The politics of such engagements are fraught. Some countries have high birthrates and these countries often export much of the resources that are needed to live off. Other countries with lesser populations are advanced, including capitalist countries whose lifestyles and wealth consume enormous amounts of the world’s resources. The United Nations International Conference on Population and Development (ICPD) held in Cairo in 1994 changed population issues to being not only about demographics but all about sustainable development. The Conference's Action Programme from Cairo met and during its assessment five years later, the issues arising out of populations were the same: abortion, sexual rights, young people and adolescents.

For the International Conference on Population and Development in Cairo, the governing concepts are not “race" and “sterilisation" but “sustainable development" and “family planning." Sterilisation is still the most heavily applied instrument of birth control or “family planning" in the developing sector. In Brazil, a 1986 investigation found that 44 percent of women of childbearing age had been sterilised.

U.S. History Of Eugenics

Dr Stephen Sodeke who is the Director of the Tuskegee Bioethics Institute discussed widely the history of eugenics in the U.S and how it impacted on Black peoples:

> “In the United States eugenic policies grew in the late 19th and early 20th Centuries. Between 1850 and 1880, the states had built many prisons, hospitals, insane asylums, and colonies for the mentally retarded. Conditions were poor in these facilities. It was Richard Dugdale, a well-to-do Englishman, who lived in New York City, and an ardent social reformer, who sought to improve the facilities. While inspecting prisons in upstate New York, he discovered a large family many of whose members seemed to inhabit one state facility or the other. His book, The Jukes, reported his exhaustive study of the family and detailed the cost to taxpayers of their incarceration and support. He also championed the core beliefs among many Americans that feeblemindedness, epilepsy, drunkenness, criminality, and insanity had strong hereditary influence, and that affected individuals tended to produce larger than average number of offspring.
>
> Charles Davenport, a talented biology professor, took interest in Gregor Mendel’s work with peas and the laws of inheritance, which came to be known as “Mendelism” in the United States. He was quick to apply the theory to the problem of human heredity. In 1905 he secured funding to establish the Eugenics Record Office, and employed Harry Laughlin, a midwestern high school teacher, to direct the office. Both are credited with tying human genetics to eugenics, and this provided eugenics the scientific basis that became very popular for three decades. From 1918 to 1939, Harry Laughlin played a major role in strategising for the eugenics movement in the United States. Laughlin’s work on sterilisation found its way to Nazi Germany where Adolph Hitler used it with devastating results.
>
> Laughlin was instrumental in securing the enactment of federal laws to limit the immigration of persons that he and many others considered inferior stock. He conducted and published survey to show that immigrants from southern Europe and Russia were much likely than immigrants from northwestern Europe to end up in charity hospitals or need public assistance. In 1922 he was the official expert on eugenics to the committee in the United States charged with immigration matters. He also drafted and lobbied for the enactment of laws to permit state officials to sterilise institutionalised retarded persons without their consent. This led to many sterilisation laws and marriage restriction laws that allowed castration, vasectomy and oophorectomy of those deemed “unfit” including the poor.

The constitutionality of the Sterilisation Without Informed Consent Law was tested in court in Buck v. Bell in 1924 in the state of Virginia. The United States Supreme Court upheld the general practice and procedure under the old Virginia statue as constitutional. By 1974 an estimated 100,000 to 150,000 low-income persons have been sterilised annually under federally funded programmes. These had included minors and incompetents, and an indefinite number of the poor coerced into accepting sterilisation under the threat that various federally supported welfare benefits would be with drawn unless they submitted to irreversible sterilisation.

Federally funded family planning programmes sprung up in the states. Depo-Provera injections were used as experimental contraceptive. The experience of the Relf sisters in Alabama who were sterilised without their consent by authorities in Montgomery, Alabama led to the case Relf v. Weinberger when the court ruled to restrict the circumstances under which recipients of federal funding could conduct sterilisation. Thus the administration of Depo-Provera to the Relf children was compulsory contraception, a eugenic alternative to compulsory sterilisation.

Today, there are still examples of eugenics programmes in the United States. There are government maternal and prenatal health care programmes. There is also the use of the courts to collect "wrongful birth" damages from health professionals whose negligent failure to provide appropriate genetic counseling or testing results in the birth of a child with genetic diseases or abnormalities. For example, in Taylor v. Kurapati, 1994, the plaintiffs Brandy and Brian Taylor appealed the trial court's order granting summary disposition in favor of the defendants Surender Kurapati, M.D., and Annapolis Hospital with respect to their wrongful birth and negligent infliction of emotional distress claim to the Michigan Supreme Court. The Court ruled that the wrongful birth tort should not be recognised, and dismissed the case."

Medicine And Eugenics

In 1972 news broke of a medical experiment that had been undertaken on Black men in Tuskegee, Alabama. Between 1932 and 1972, the United States Public Health Service monitored the progression of syphilis in 399 patients in Alabama, most of whom were poor sharecroppers, many of whom who could not read, all of whom were black men. The aim of the experiment was to see what the effects of syphilis are over a long period and to see if survival was possible and indeed who would survive. The Tuskegee experiment, which exposed racism in medical science, was premised on the idea that Africans are sexually loose and particularly prone to carry sexually transmitted diseases. (Jones J 1993)

Dr. Bill Jenkins, Professor of Public Health at Morehouse College and former Manager of the Centers for Disease Control's Health Benefits Program, handled the medical needs of survivors of the experiment and their affected families. He was to point out that Tuskegee was not an isolated incident:

> "The history of America is a history of race. Medicine was no more immune from the plague of white supremacy than religion, politics, art or any other area of human endeavor. The early relationship between black people in this country and the medical sciences had the specific goal of restoring health to slaves in order to keep them in the fields producing profit for white slaveholders. Often medicine was directed at reversing the physical injuries to slaves that had been suffered at the hands of those very same slaveholders. In 19th Century America, "dissection" of the human body after death was widely considered an abomination and often forbidden by state laws. Entire generations of white medical students perfected their surgical crafts by practicing on the black bodies — either stolen from the graves or purchased — because Negroes were offered no such legal protections. Former slaves often told of "night doctors" who stole bodies from burial grounds for delivery to medical schools. It is no coincidence that Nat Turner's body was turned over to a group of physicians for dissection after he was executed."

Historically Black people had been subjects of (or subjected to) medical racism. Dr Sam Cartwright, a 19th Century doctor had discovered an illness that he called Drapetomania. It was a mental illness that he claimed caused slaves to run away from plantations. The cure for the illness he said was to administer repeated floggings. He also described a condition called Dysaesthia Aethopia which was supposed to cause slaves to be sleepy, be mischievous and to be insensitive to pain. Other illnesses were given names such as 'Negro consumption' which was explained as being caused by superstition rather than physical causes.

Issues of sex and reproduction brought particular violations. One historian reported that in Louisiana caesarian sections were performed *exclusively* on slave women because of the high mortality rates for abdominal surgery during the era. Black women literally became the practice field for procedures that would later save the lives of white women.

During the Second World War army medical doctors maintained a separation between Black men and others, and transfusions for blood saw further segregation.

Nancy Ordover argues that the eugenics movement and ideologies were not just driven by scientific racism but also by liberals and a reliance on the 'technofix', a distraction from the need for more basic social changes. She argues that "for the poor, the racialised and the criminalised, tubal ligation, hysterectomies and vasectomies were never value free medical procedures" (xxvii Ordover 2003).

Racial and ethnic differences to the way patients are treated now are obvious. Benefits of medical treatment are not necessarily equally distributed and certain other procedures are more widely distributed. Examples such as the usage of depo provera on Maori girls bear this out. Histories of birth control in developing countries and ethnic populations also bear this out, such as the use of quinacrine, testing on women in the Middle East, Latin America and Asia.

Part IV: Indigenous And Eugenics

Indigenous And Eugenics

The history of the genetically unfit has been linked with colonisation. The export of the 'unfit' classes from England to colonies such as Australia was one such interconnection. Also within policy some of the effects of colonisation were removal of children and raising them in white families. Dispossession of land was in the Indigenous mind a eugenics policy and laws such as raupatu or confiscation of lands were carried out as 'the unfit' were defined as 'rebels' or enemies of the state. But its also important to see the matrices of interconnection between colonisation and eugenics, to see how there is a specificity to eugenics for Indigenous Peoples as well as an overlap into other unfit groups. If eugenics is the application of theories of fear and hate, then Indigenous Peoples are a group of enemies within the nation state. Racism, xenophobia, homophobia, misogyny, ageism, ableism and classism class are all aspects of eugenics.

Eugenics arises in response to perceived external and internal threats such as those posed by immigration and the overwhelming of the population by the 'other' and also by degeneracy. These views are widespread and can be seen in the discussions around Maori and urbanisation for example and the goals of education which advocated the movement of Maori children away from the demoralising influences of their homes. (Simon J et al) The history of Chinese immigration into New Zealand meant that legislation was passed to reveal the 'inadequacies' of the Chinese immigrant – such exposure was achieved through methods such as English literacy to show lower intelligence, lack of moral fibre, and physical handicap.

There were calls to 'nation building' as part of the eugenics plans which basically pivoted around building a strong country with good British stock. Etienne Balibar in his book Racism and Nationalism writes of the nation and the integral relationship of race to nationalism. In other analyses:

> "The analytical relationship of 'race' to state is still highly contested. In today's atmosphere of the heightened repression of immigration, racist policy-making masquerades as concern for social cohesion under threat from too much diversity or is linked to the security agenda of the post-9/11 world. Under these conditions, we witness a return to the old patterns of the 'social antisemitism' described by Arendt, this time targeting Muslims and the 'brown' skinned. The racialisation of Islam and the criminalisation of migration, controlled in detention centres and camps, finger printing, electronic tagging, and ultimately expulsion exemplify the practical implementation of the mechanisms of biopower in societies increasingly governed by fear of the unknown, symbolised by the archetype of the 'stranger'." (Race and State Conference flyer for 2005)

In contrast Kevles argues that eugenics was mainly about divisions among whites:

> "In the United States, however, the biological distinctions that mainly obsessed eugenicists were not those between whites and blacks, but those then believed to divide whites -- differences between the old-stock white, Anglo-Saxon, Protestant majority and the numerous Catholic and Jewish immigrants from Eastern and Southern Europe."

However he is conservative in his views: Indigenous/Black analysts assert that populations such as Blacks and Indigenous were victims of eugenics but yet they were not being explicitly discussed in the histories of eugenics.

Maori Views

Some Maori are currently arguing that ideas of whakapapa contain aspects of genetic determinism. There needs to be a clear distinction here. Whakapapa emerges from a completely different world view. Whilst Maori do talk about inheriting traits from previous tupuna there is a great deal of difference to this talk; it is different from genetic determinism. The reasons for this difference are many. Firstly, Maori recognise a range of aspects to human-ness which are not recognised within the scientific tradition. Also 'traits' are different. (Mead 2003) The transmission of knowledge is also important: how Maori view the transmission of knowledge affirms a whole range of aspects that are missing in scientific paradigms.

Unfortunately whakapapa is under scrutiny in regard to genetic determinism when in fact it is unrelated. Whakapapa was however concerned with the transmission of knowledge, of wairua and other elements. It centers around the construction of and addition to layers of existence and focuses on what the layers consist of. The basis of genetic determinism includes evolution theories and it is deeply rooted in ideas of class, gender and race. Currently much is made of the fact that there is a 98% genetic similarity between chimpanzees and humans. Whakapapa has never been just about biological relationship although some writers assume that is the case. Within all rohe there is the assumption of whakapapa relationship with non-humans. For example, tupuna awa is a reference to ancestral rivers. The range of relationships that Maori assert within whakapapa extends beyond belief within the western scientific tradition. It is relationships with all of our relations.

Whether we``` will 'refine' our beliefs in line with scientific discovery or 'new knowledge' depends on a whole lot of factors:

- will we be asked what we think?
- will we believed when we say what we think?
- can the scientific tradition cope with what we think?
- will the ways in which we assess rights and wrongs be taken seriously? (Mead 2003)

There are many levels and layers of omissions and deletions of the record, as Maori policy makers, advisors, consultants and many others delete the references to the wider relationships.

Monte Aranga of Ngati Awa, discussed the notion of eugenics emerging from a completely different world view and another philosophical basis: "the assumptions underlining the word eugenics are derived from another worldview."

He noted that Maori concepts did not emerge from ideas of higher beings and lesser beings: "The moe rangatira concept was predominantly political to whakanoa conflicting forces rather than cultivate a master race."

In response to the question of whether Maori traditionally had notions of the 'fit' and 'unfit' he replied that,

> "No also, to the Darwinian notion of fit and unfit. Suitability for particular tasks and activities was evident for instance the rangatira who was able to gather, look after and lead the group (tira) or tohunga, someone who was marked (tohu) as having certain abilities. Koretake has utilitarian connotations but comes close to `unfit' but there still doesn't seem to be an equivalence here. The latter refers to cause, reason rather than physical aptness."

Dr Paul Reynolds also critiques the world view of science by saying that although Maori have selective breeding of plants, there were fundamental differences in world view to the approaches taken:

> "It's dependent on world view basically. And it's a world view about concepts of life and what, life is and respect for life. So, there's a whole conceptual...not layer...but a whole conceptual basis around how Maori and other Indigenous people view life and, the eugenics processes and that don't fit into that conceptual frame work which Maori and, and other Indigenous Peoples have around life and respect for life.
> So, that's the starting point, so scientists don't start from that same starting point. They're not at the same level, they're not at the same foundational value level. So they're never going to be able to even comprehend the differences in valuing of life, in general. So when we have selective breeding for the potatoes, for the growing of potatoes for example then this is a valuing of that life of our food source but, also a valuing of and a respect when using that food source that there are different processes that you actually go through to respect the potato, to respect the environment that the potato lives in, to respect how it's going to be used as kai, how it's going to be used for the whole whanau, hapu, iwi."

Much of the literature on eugenics excludes mention of Indigenous Peoples. There is an enormous gap in the writing. Because of that, interviews were important for talking about the issues. The following section outlines one specific area of eugenics issues and Indigenous Peoples, that is, the forced and coerced sterilisation of Indigenous women.

Forced Sterilisation Of Indigenous Women

The forced sterilisation of Indigenous women continued right up into the 1980s by the Indian Health Service. They would give women hysterectomies without their prior knowledge, much less consent. This systematic policy, which was never publicly articulated, actually threatened the survival of several Western nations. I believe that was the whole purpose of it. K'chi weliwoni, Bean. (Posted by: Nikkiru on March 10, 2004)

The testimony above and others from Native American peoples affirm that sterilisation of their women was a practice carried out for many decades in the U.S Groups[140] working with Native American women have collected testimony and have made estimations of how widespread the practice of forced sterilisation was, the prescription of unsafe use of Depo-Provera and Norplant, and destructive alcohol-related policies.

> "A study by the Government Accounting Office during the 1970s found widespread sterilisation abuse in four areas served by the Indian Health Service. In 1975 alone, some 25,000 Native American women were permanently sterilised--many after being coerced, misinformed, or threatened. One former IHS nurse reported the use of tubal ligation on "uncooperative" or "alcoholic" women into the 1990s. Complaints of these unethical sterilisation practices continued, but little was done until the matter was brought to the attention of Senator James Abourezk (D-SD). Finally, affirmative steps were taken - specifically the commissioning of the General Accounting Office - to investigate the affair and to determine if the complaints of Indian women were true - that they were undergoing sterilisation as a means of birth control, without consent. (65) The problem with the investigation was that it was initially limited to only four area Indian Health Service hospitals (later twelve); therefore[sic?], the total number of Indian women sterilised remains unknown. (66) The General Accounting Office came up with a figure of 3,400 women who had been sterilised; but others speculate that at least that many had been sterilised each year from 1972 through 1976. (67) From a statistical point of view, the reality of the devastation of Native American women victimised by sterilisation can be observed through the comments of Senator Abourezk himself: "given the small American Indian population, the 3,400 Indian sterilisation figure [out of 55,000 Indian women of childbearing age] would be compared to sterilising 452,000 non-Indian women." (74) (Defines article)

These practices continue today through coercion and misinformation according to the Women of Color Partnership (Salaita).

International Statements On Sterilisation Of Indigenous Women

There are a number of international statements that draw attention to the continued sterilisation of Indigenous women and some of those are outlined here:

1. UNITED NATIONS GENERAL ASSEMBLY

Article II of United Nations General Assembly resolution, 1946: In the present Convention, genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnic, racial, or religious group, as such: (d) Imposing measures intended to prevent births within the group. In the mid-1970s a Choctaw-Tsalagi Indian Health Services doctor was approached by a 26-year-old American Indian woman who desired a "womb transplant." She had been sterilised when she was 20 at the Indian Health Service hospital in Claremont, Oklahoma. It was discovered that 75 percent of the Claremont sterilisations were non-therapeutic, that women American Indians were being prompted to sign sterilisation forms they did not understand, that they were being told the operations were reversible, and that some women were even being asked to sign sterilisation papers while they had yet to come out of birthing sedation.

140 Native American Woman's Health Education Resource Center

2. BEIJING DECLARATION OF INDIGENOUS WOMEN

International concern continues to be expressed that the forced sterilisation of Indigenous women is ongoing in some countries. Added to this is behaviour and policy regarding birth control and family planning. At the 1995 Beijing Women's Conference there were calls for a halt to the impacts of coercive birth control and the targeted sterilisation of Indigenous women which continues in some countries:

Article 28 of the Beijing Declaration of Indigenous Women stated:

> "We demand that coercive family planning services, like mass sterilisation of Indigenous women, coercive abortion programmes, be stopped. That population policies like transmigration be condemned and halted."

3. COMMITTEE ON THE ELIMINATION OF RACIAL DISCRIMINATION

During its 56th session the Committee on the Elimination of Racial Discrimination adopted two General Recommendations:

> "No. 25. Gender-related dimensions of racial discrimination
> In this General Recommendations[sic] the Committee notes that racial discrimination often impacts men and women in different and unequal ways. Certain incidents only affect women, whilst others affect women in different ways to men. Often specific forms of racial discrimination have been directed towards women on account of their gender. This includes sexual violence against women of a particular race or ethnicity during armed conflict and the coerced sterilisation of Indigenous women. Pregnancy as a result of racially motivated rape was also a prevalent problem. Women can also be hindered by a lack of access to remedies or complaint mechanisms for racial discrimination, due to gender related restraints. Furthermore, the General Recommendation specifically recognises that some forms of racial discrimination have a unique, specific impact upon women."

4. PERMANENT FORUM ON INDIGENOUS ISSUES

At the Permanent Forum on Indigenous issues in May 2004, discussion arose about the forced sterilisation of Indigenous women:

> "Responding to another question, Mr. Magga said that one of the recommendations on Indigenous women asked the Commission on Human Rights to appoint a rapporteur to designate a study on genocidal practices against Indigenous Peoples, including forced sterilisation of Indigenous women and girls, and the use of Indigenous communities as subjects of nuclear testing or storage of nuclear waste. The reason for that proposal was real maltreatment in many countries, which needed to be reported."

> "05/22/04 - The Permanent Forum on Indigenous Issue closes
> The Permanent Forum on Indigenous Issues closed its third session today. Dedicated this year to exploring the plight of an estimated 170 million Indigenous women and girls in the world, the Forum recommends that the United Nations undertake a study on genocidal practices, including programmes for the sterilisation of Indigenous women and girls. The Permanent Forum is a United Nations body composed of 16 experts nominated by governments and Indigenous organisations."

5. WORKING GROUP ON INDIGENOUS POPULATIONS

> "Report of the Working Group on Indigenous Populations on its seventeenth session
> (Geneva, 26-30 July 1999)
> Chairperson-Rapporteur: Ms. Erica-Irene A. Daes
> 116. An Indigenous representative from Peru referred to a family planning programme in his country which, instead of providing health care, was promoting sterilisation of Indigenous women without consulting them. The sterilisation programme was made easier because many native Indigenous women were illiterate."

In 2002 the news media[141] released the news of mass sterilisation on Indigenous Peoples in Peru. A Peruvian leader apologised for the 200,000 forced sterilisations of poor Indigenous women – in Peru. Many were pressured into sterilisation with threats and bribery. Within a period of four years from 1996 to 2000 surgery was performed on 215,227 women and 16,547 men. This was in contrast to 82,000 in the previous three years.

Part V: Biotechnologies And Eugenics

> "Poverty…. is the world's deadliest disease"[142]

> "Most people the world over die not because they have 'bad genes' but for lack of sufficient and nutritious food, clean water, sanitation, and vaccines and other inexpensive medications"[143]

Human Genetics And Eugenics

The literature on the field of human genetics shows a range of views, from those who uphold and defend its importance to those who regard it as based on false assumptions and simplistic in its discussions of the complexity of life.

> "Instead of the term eugenics, with its incendiary associations, the preferred label is now the more neutral "human genetics." However, remnants of the eugenic philosophy can be discerned in practices like premarital blood testing, IQ and other standardised tests, and so-called free market solutions to social welfare." (Black – War Against the Weak)

Writers such as Mae Wan Ho calls gene biotechnology 'bad science'. Commenting that she is a scientist herself she points to much of the worlds problems being caused by 'bad science' that reduces the complexity of life to an exploitative, reductionist and manipulative world view.

> "Eugenics is surfacing again as human genomic science, spawned by the sequencing of the human and other genomes and is now promising to identify all the 'bad' genes that cause diseases and disabilities so that they can be eliminated at conception or before birth while the good genes can be used for the genetic enhancement of anyone who can pay for the privilege. This time round eugenics will not be sanctioned by the state. It will be up to the global market to decide. The poor will become a genetic underclass. Social inequality will be redefined as and transformed into genetic inequality." (Mae Wan Ho 2003: ii)

Other writers such as Daniel Kevles argue that while eugenics may have been part of the debates about heredity in the past, that things have changed today:

> "Eugenics took popular hold after the turn of the 20th Century, flourishing for several decades. During its heyday, social prejudice suffused human genetics, often attributing to genetics social differences that were actually rooted in race and class. After World War II, however, biologists in the United States and Britain fought -- by and large successfully -- to emancipate human genetics from such biases in order to establish it as a solid field of science that would explain the complexities of human heredity and assist medicine by illuminating the relationship of genetics to disease. During the past 50 years, molecular geneticists have located, isolated, manipulated, and analysed thousands of human genes, including many implicated in diseases and other conditions. Their work has been greatly accelerated by the Human Genome Project, which began in the late 1980s and which in 2001 completed a first draft of the entire sequence of DNA in the human genome." (D Kevles)

The publication of the book, The Bell Curve by Charles Murray and Richard J Herrnstein in 1994 set off a storm of reaction in the U.S. It sparked again the debates over race, intelligence and genetics because the book claims that racial groups are different because of innate mental abilities. They argued that Blacks score lower on IQ tests and they are less intelligent.

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141 BBC Mass Sterilisation Scandal Shocks Peru Wednesday, 24 July, 2002.

142 World Health Organisation Director General Hiroshi Nakajima in 1995 quoted in Hubbard and Wald 1997

143 Hubbard and Wald point in the above quote to the more than one million children who are still dying from measles when the vaccine for each child would cost 15c U.S They also point to the 12.2 million children under 5 who die from treatments that would cost less than 20c per day (P163). The above quote points to a fundamental question about poverty and allocation of monies to 'save lives'. Globally the issues of which lives are worth more, whose lives are worth saving and how much will one spend on others lives are all questions that are fundamentally eugenics questions.

Because of a genetic predisposition Blacks will be more likely to be poor, criminal and on welfare, single parents. They also argued that 'dysgenics' was the outcome which was resulting in an increase in poor genes into the wider population. The book was loudly applauded by neo-conservative groups within the U.S. There was a raft of responses to the arguments made in the book. Educationalists and academics have responded widely to the views expressed and the implications – the central argument being that certain groups of children because of their race were unworthy of educational attention and the allocation of resources. (Kincheloe J, Steinberg S, Gresson A)

Science And Markets

The development of the biotechnology industry is tied in to the development of free trade and the establishment of economic goals by the U.S, Europe, Australia and New Zealand to commercialise biotech research. The development of 'life sciences' or molecular biology is seen as an important area of research. The New Zealand Government released its biotechnology strategy in 2003. The aim is to develop products across a range of areas, food production, pharmaceuticals, bioproducts, fertility treatments and others. All of these countries view biotech development as a critical economic pathway and have invested in research and development. The following quote is from an Asia Pacific trade meeting and gives an idea of the taken for granted economic imperatives being discussed:

> "'Commercialisation of biotech research through effective industry-academia linkage is a critical success factor for the industry,' say the analysts of this research. 'The Asia Pacific region needs to build the element of commercialisation into the mindset of its researchers in government-owned labs and universities to unlock the latent potential of the huge science and technology manpower base as well as the knowledge base it houses.'"

The economic goals of States have clashed with Indigenous Peoples, biodiversity and traditional knowledge. Concerns over new forms of 'plunder' of Indigenous Peoples genetic material, blood and knowledge has resulted in a number of highly publicised cases, when informed consent was over- ridden. Opposing the patenting of life forms and biopiracy Indigenous Peoples have formed coalitions internationally. At many international meetings including the Convention on Biodiversity, large delegations of Indigenous Peoples are attending and voicing opposition to the removal of safeguards on the heritage, traditional knowledge and biodiversity of their Peoples. (Tauli- Corpuz 2003)

Reproduction And Infertility

As rates of infertility get higher[144], particularly in advanced capitalist countries there is a concern about the falling birth rate but also the resources to develop expensive fertility treatment and research. There is now a proliferation of possibilities in which sterile couples can become pregnant.

1. The man's sperm can fertilise the partner's egg.
2. The man's sperm may fertilise someone else's egg.
3. The man's sperm can be implanted into the oviduct of his partner
4. The man's sperm can be implanted into someone else's oviduct.
5. The sperm and egg can be fertilised in a glass dish.
6. The embryo may be nurtured in the mother's womb.
7. The embryo may be nurtured in someone else's womb.

The success rate when surgical procedures are involved according to Carlson pan out at about 10-40%. (Carlson 2001:390) Expenses for these procedures can vary.

144 Newsweek Sept 27 2004 wrote a story called Baby Bust: For More and More Countries, The Problem Isn't Having Too Many People, But Having Too Few. The article pointed to the fact that the 50 poorest countries will treble in population by 2050 but that European countries and parts of Asia are also declining in replacement populations.

How Do Eugenics Questions Arise In Biotechnology?

There is an increasing number of ways that biotechnology developments raise eugenics questions in the following areas:
Human genome project
Stem cells and human tissue
Xenotransplantation
Behavioural genetics
Population genetics
DNA testing – gender, disability, criminal and health, predisposition to...., intelligence, physical traits
Nanotechnology
Inserting of genes into sperm
Designer babies
Pre-implantation genetic diagnosis
Embryo selection
Human cloning

In a number of procedures embryo selection is made. Judith Levine (2002) points out that when doing cloning research Scottish biologist Ian Wilmut, the scientist who created Dolly the cloned sheep, provided statistics in 2001 that showed the small numbers of successful embryos from the thousands that were created:

> "Of the 31,007 sheep, mice, pig, and other mammal eggs that had undergone somatic cell nuclear transfer (cloning), 9,391 viable embryos resulted. From those embryos came 267 live-born offspring. In these animals, The New York Times reported, "random errors" were ubiquitous—including fatal heart and lung defects, malfunctioning immune systems, and grotesque obesity. In all, 'fewer than 3 percent of all cloning efforts succeed.'"

While Dolly the sheep was initially seen as a triumph she later suffered from bad health problems including arthritis and premature ageing. Levine questions the ethics of cloning humans:

> "How might the process be perfected in humans? In clinical trials? "The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment," reads the Nuremburg Code, drawn up after World War II to forbid future torturous experiments of the sort Nazi "scientists" inflicted on concentration-camp inmates. What is the humanitarian importance of creating a faster 100-meter sprinter?"

Stem cell research is particularly contentious as it can require the creation of embryos for research purposes and then the destruction of embryos specifically for research purposes. There are high profile opponents such as Leon Kass, Chair of the U.S Presidents Bioethics Council, George Bush and the Pope. There are also high profile advocates such as Michael J Fox and Arnold Schwarzenegger.

Sex selection abortion rates are already high in certain countries where state policies are restricting numbers of children. In those countries some are experiencing higher numbers of second trimester abortions and illegal abortions. Higher ratios of boys are wanted often because boys are perceived to have higher value if there can be only one child.

Designer Children

> "I began paying attention to these sorts of questions several years ago, after reading Princeton molecular biologist Lee Silver's notorious account of the new human genetic and reproductive technologies in his book, Remaking Eden: Cloning and Beyond in a Brave New World. Silver enthusiastically predicts that well-off parents will one day soon choose their children's DNA from a biotech catalogue. This new market-based mode of childbearing is inevitable, he says, and will lead to the emergence first of genetic castes, which he dubs the "GenRich" and the "Naturals," and thereafter of separate human species." Marcy Darnovsky

Discussion of designer children is emerging as technologies grow and are offered to couples. On the internet a number of companies in the U.S, such as Microsort, are openly advertising sex selection for children or 'gender balancing' of families. The costs of the treatment of sex selection range from $2300 to $10,000 U.S. Some spokespeople for clinics are pointing out that they are being asked by parents for children with particular traits such as hair colour and eye colour.

Sperm Banks

The idea of controlling human breeding through trying to determine the fitness of sperm/eggs/embryos goes back a few decades. In the 1940s in the U.S Herman Muller, a Nobel Prize winner in medicine who was studying genetics became alarmed at the degeneration of the genetic pool. He began to advocate for the establishment of 'germinal repositories' or sperm banks to store the sperm of men who were strong, healthy and distinguished. The idea did not go far until the decades later and Robert Graham who was a positive eugenicist became interested in the idea. In 1979, Robert Graham, millionaire, established a sperm bank where sperm from those with high I.Qs was stored. Graham said that he wanted to see a better society, where children were smarter with parents who were healthy and stable. One high profile donor to the sperm ban was William B. Shockley a Nobel Prize winner who was outspoken in his views that Blacks, are not as intelligent as whites because they are genetically deficient. In 1984, Mr. Graham claimed he was looking for donors who are outstanding athletes. Graham held out a dream that the elite sperm banks would proliferate but only two others were set up "Heredity Choice" and Foundation for The Continuity of Man". While the eugenics of the 1920s was about public health and ideas of national breeding stock, the new positive eugenics seems to advocate for a privatised positive eugenics based on consumer choice.

Embryo Research

Also being researched is the possibility of children who have two genetic mothers:

> "Recently, the Institute for Reproductive Medicine and Science at New Jersey's St. Barnabas Medical Center announced the success of a new fertility "therapy" called cytoplasmic transfer, in which some of the cellular material outside the nucleus of one woman's egg is transferred into the egg of another woman who is having difficulty sustaining embryo survival. The transferred cytoplasm contains mitochondria (organelles that produce energy for the cell), which have a small number of their own genes. So the embryo produced with cytoplasmic transfer can end up with two genetic mothers. This mixing, called "mitochondrial heteroplasmy," can cause life-threatening symptoms that don't show up until later in life. When the Public Broadcasting Service's Nova enthusiastically reported on the procedure, complete with footage of its cute outcome, Katy, it mentioned no risks." (Levine J 2002:26)

Pre-implantation genetic diagnosis (PGD) tests early-stage embryos produced through in vitro fertilisation (IVF) for the presence of a variety of conditions. One cell is extracted from the embryo in its eight-cell stage and analysed. Embryos free of conditions that would cause serious disease can be implanted in a woman's uterus and allowed to develop into a child.

Critics of pre-implantation genetic diagnosis say that it is the first step to eugenics technology because it screens embryos for genetic traits, which are either desirable or undesirable. Who will be defined as the fit or the unfit? Disability groups have criticised the definition of disease saying that it is a fine line and can be subjective. Women's rights groups have said that decisions to terminate life should not be on 'traits'.

Levine points out that the issues of genetic reproductive technologies have formed some unusual alliances, driven by media framing how the protagonists will slog it out:

> "When proposals to ban human cloning were introduced in the U.S. House of Representatives a year ago, progressive opponents of genetic engineering were only partly pleased. The problem was, the legislation did not come from other progressives, or their friends. Rather, the Bills were all sponsored by hard-right supporting a ban on reproductive cloning and a moratorium on embryo cloning. organisations have been slow to understand species altering technologies as their issues. This hasn't been true in Europe and the global South, or among Indigenous women in North America. In 1992, for instance, European Green Party women discovered a patent application from a U.S. biotech company for a process to synthesise nonhuman "biological active agents" in human mammary glands, from which they'd be secreted in milk and transmitted to nursing infants. To dramatise the commodification of women that lurked in this idea, the women's propaganda featured the image of a pregnant belly with a bar code emblazoned across it. It was one of the first feminist campaigns against patenting Republicans like Florida Congressman David Weldon and Pennsylvania's James Greenwood, and the Bills' loudest supporters were anti-abortion fundamentalists. This demanded fast and tricky politicking. The sponsors' sympathies, showing more tenderness toward blastocysts than toward living women and children, made pro-choice representatives want to run in the other direction. "The problem with the Weldon Bill was Dave Weldon," said Judy Norsigian, executive director of the Boston Women's Health Collective, after lobbying the House on behalf of that Bill. The press fanned moderates' misgivings by

characterising the debate as one of science versus religion, or of medical progress versus Luddite alarmism." Levine 2002:27

Feminist Writing On New Reproductive Technologies

Dr Alison Jones, educationalist at the University of Auckland talks about the fact that there is no such thing as feminism but rather that there are a range of views within the area broadly called feminism. For many women's groups, abortion rights have been a bottom line issue for them. Marcy Darnovsky argues that women's rights groups initially did not engage the development of biotechnologies but are now becoming more politicised and vocal on the issues of genetics and reproductive rights. Some writers are clearly differentiating the technologies:

> "Industry promotion of biotech eugenics favours individual choice for paying customers or 'consumer eugenics' as Barbara Katz Rothman calls it. This language has co-opted the language of abortion rights advocates who promote the women's right to choose. Some feminists believe that if the rights of embryos are advocated for that will cause the anti abortion lobby to get stronger. Marcy Darnovsky differentiates between abortion and reproductive technologies by saying that women should be able to choose whether or not to have a baby but that does not mean that modification is ok of embryos." (in Levine 2002).

> "Radical feminists have powerfully demonstrated that the new reproduction enforces traditional patriarchal roles that privilege men's genetic desires and objectify women's procreative capacity. They make a convincing case that new reproductive technologies serve more to help married men produce genetic offspring than to give women greater reproductive freedom. High-tech procedures resolve the male anxiety over ascertaining paternity: by uniting the egg and sperm outside the uterus, they '[allow] men for the first time in history, to be absolutely certain that they are the genetic fathers of their future children.'" (Roberts, Dorothy in Race and the New Reproduction)

Research On The Gay Gene

Although there is no research on the heterosexual gene, the transvestite gene, the transsexual gene, the transgender gene, there is research being done on a 'gay' gene. There is clearly a range of expressions to human sexuality and sometimes a fluidity to sexuality, which would lead to the conclusion that it is not just genetic factors that determine sexuality.

> "Theories about women, hormonal limits to achievement, genes explain lesser intelligence, irrationality etc. Now the old determinism is raising its ugly head once again, with genetics. As "non-traditional" families finally bring legitimacy to social parenting, proponents of inheritable genetic modification tell us not only that we can pre-determine the natures of our children, but that cloning is the only means by which gays and lesbians can become real parents. "Real" parental ties, they imply, are biological, genetic. "Genetic determinism" is not biologically accurate. "It is very unlikely that a simple and directly causal link between genes and most common diseases will ever be found," writes Richard Horton, editor of the British medical journal The Lancet." (Levine 2002:28)

Some gay researchers have become involved in research to look for a gay gene. Given the stigmatising of homosexuality, there have been some attempts by gay researchers to prove a biological basis to homosexuality. The desire to prove a biological basis is understandable given the range of 'programmes' and range of 'treatments' that the gay population has been subjected to such as shock treatment, aversion therapies and others.

Randy Shilts who wrote the book "And The Band Played On", is one such person who believes that if it could be proven that homosexuality is biological then "it would reduce being gay to something like being left-handed, which is in fact all that it is". Hubbard and Wald (P94) point out however that even when there is a biological basis to difference such as being African, this does not diminish discrimination.

In the interview with Dr Paul Reynolds he pointed to genetic research focusing on the individual and avoiding broader social dynamics and explanations:

> "Reductionist biomedicine concentrates on identifying genetic predispositions and propensities for myriad disorders including cancer, diabetes, and schizophrenia. Geneticists have even tried to identify genes for such conditions as alcoholism, homosexuality and criminality. Focusing on the individual is problematic, however, as it 'diverts attention

from the real causes, but also stigmatises individuals, through placing the blame for society's ills on people's genes, and through the arbitrary categorisation of the 'normal' versus the 'abnormal.'"[145]

Maori lawyer, Carl Mika has written on the issues of homophobia that arise in the search for a gay gene. He critiques the Wests intense search for a 'cause', triggered by the labelling of the 'abnormal'. He argues that the dualism that the West has established called homosexuality and heterosexuality has been a pervasive colonising ideology for Maori as well:

"Hence the homosexual has been classified as abnormal, and the need to know the cause of the abnormality has become primary. This can be seen in recent attempts to discover whether sexual preferences in sheep, believed to be due to differences in hypothalamic function, can be altered by manipulating hormonal levels. The drive to 'normalise' functions, then, is still evident, albeit at a more sophisticated level."[146]

Current Legislation In New Zealand

A number of current pieces of legislation deal with human genetic issues. New Zealand is moving to review and adjust legislation as new biotechnologies are developed.

"Otago University anatomy professor Gareth Jones identifies four positions: banning all embryo research, as in countries such as Ireland and Poland; allowing the creation of embryos specifically for research, as in Britain and Singapore; using stem cells now in existence but halting future harvesting, a position adopted by the United States, Germany and Australia; and allowing the use of stem cells from surplus in-vitro fertilisation embryos - the position most likely to be adopted in New Zealand."[147]

Review Of The Human Tissues Legislation

Tissue engineering is a growing market. Medical technology has begun to develop 'products' in human tissue such as skin, cartilage and bone but there is also xenotransplantation or research that is being undertaken to examine the possibility of growing human organs inside other species. (In Europe there are 113 companies that deal in tissue products). Much of the tissue discussion is around the shortage of human organs for transplants.

A Review of the Human Tissues legislation is currently being undertaken by the Ministry of Health. A submission process was held in 2004 to consider collection, storage, transport, use and disposal of bodies, body parts, organs, tissues and specimens intended for therapeutic, research and teaching purposes. Blood, assisted human reproduction and new organisms containing human genetic material are under other legislation. The Review did not allow for comments on resource allocation or service delivery. The aim is to have legislation passed by June 2005. There is currently a ban on xenotransplantation which will expire at that time.

Hsno

The following clarification of what the HSNO Act does and does not cover is taken from the Ministry for Environment website http://www.mfe.govt.nz/publications/organisms/discussion-paper:

"Genetic Modification Of Human Cell Lines

A cell line is an established population of cells derived from tissues that will grow and divide indefinitely in the laboratory given the appropriate growth medium and space. Although the genetic modification of animal cell lines currently requires approval under the HSNO Act, the same modification of human cell lines does not. This is because humans, their tissues and their cells are specifically exempt from coverage under the HSNO Act through being excluded from the definition of an organism. Similarly, the Medicines Act covers clinical trials of new medicines involving human participants, but does not currently include laboratory research using human cell lines.

145 Ho, 1998: 35.

146 Locating the Sibilance Gene, Paper submitted for IRI journal: Genes, Genetics and Nanotechnology nov 2004.

147 NZ Herald Scientific Advances Lead to a Legislative Nightmare

Two options have been identified to ensure that genetic modification of human cell lines for research purposes is subject to appropriate regulation. The first option would involve amending the HSNO Act to include applications for the development (genetic modification) of a human cell line or the importation of genetically modified cell lines. The other option is to address this matter in the Ministry of Health's current review of human cell and tissue research, possibly with guidelines to cover the genetic modification of human cell lines in the interim.

New Organisms Regenerated From Tissues

Neither the importation of tissue samples nor any development activity (other than genetic modification) requires a HSNO approval. Improvements in cloning and related technologies since the commencement of the HSNO Act mean that it is now possible to produce an animal not currently in New Zealand (a new organism) from imported tissue using a surrogate mother, without a HSNO approval, thereby bypassing the usual requirements to fully evaluate the effects of introducing that new species of organism into New Zealand.

In addressing this gap it is proposed that the focus of the HSNO oversight remain the same; that is, on the nature of the new animals produced and their potential effects on the environment, not on the technologies themselves nor on any other direct use of the tissues.

Two options have been identified for amending the HSNO Act to include new animals produced using cloning and related techniques: either amend the definition of 'develop' to cover the regeneration of new organisms, or broaden the definition of 'new organism' or 'organism' and include a power to make regulations to provide that things are not 'organisms' or 'new organisms' for the purposes of the Act. It is proposed that the amendments extend to the artificial regeneration of organisms from all tissues, including plant and fungal tissues that are not capable of replicating themselves.

The proposed amendments would not extend to human cloning as the term organism in the HSNO Act specifically excludes human beings."

Human Assisted Reproductive Technologies Act 2004

Under the Medicines Act 1981 a temporary ban was placed on genetic modification of sperm, eggs and embryos, human cloning and xenotransplantation in the year 2002. NECAHR, the National Ethics Advisory Committee on Assisted Human Reproduction has maintained an overview of ethical issues to do with assisted reproductive technology but without legal guidance.

The Human Assisted Reproductive Technologies Bill was introduced by Diane Yates in 1996. It was passed in November 2004 The HART Bill was supported 102-18 in a third-reading Parliamentary vote November 10, 2004. The Act allows pre-implantation genetic diagnosis. Diane Yates felt that the legislation did not go far enough:

> "There are parts of the Bill, for instance taking a sperm or gametes from dead people, PGD (pre-implantation genetic diagnosis), some issues that are left to guidelines - even the consent process - I would much rather have it as a regulation with penalties involved, but the House didn't agree,' she said."[148]

The process for undertaking procedures and research will be on a case by case basis. Guidelines are to be developed by a ministerial advisory committee and then applications will go to an ethics committee. The Greens critiqued the Bill in terms of its lack of regulatory process. The Act will leave a great deal of power in the hands of the current and future Ministers of Health.

The only Maori writer who has written on the eugenic potentials of human biotechnologies is Tremane Barr of Kai Tahu. In a paper critiquing the Human Assisted Reproductive Technologies Bill he wrote that:

> "The Medicine Act 1981 outlawed germ-line genetic modification, but this was weakened in 2002 Labour when they partially legalised it by restricting its use to only those the Minister of Health approved. The 2002 Select Committee report on this law noted that this change in law 'will mean that procedures that may be of great benefit, such as those to prevent genetic diseases, could theoretically be authorised but procedures to generate designer babies for non-health reasons would be less likely to be approved.'"

148 NZ Herald 12/11/2004 Reproduction Bill Better Than Nothing After Eight Year Wait.

Disability Groups

Concerns have been expressed by a range of disability groups over developments in human biotechnologies. The issues raised are such concerns over eugenics of the disabled. They also ask such questions as who defines what is a disease. Ableism, the fears of the disabled, are issues that disability groups have been trying to deal with and within New Zealand this has seen an upsurge in programmes that deal with 'destigmatisation'.

> "The organisation Disabled People International met in October 2002 in Sapporo Japan to discuss just these types of issues that affect the lives of 600 million disabled people world-wide. On the topic of bioethics and the new eugenic technologies they declared:
>
> We demand the right to be different
>
> We believe that no parent has the right to design and select their unborn child to be according to their own desires and no parent has the right to design their born child according to their own desires.
>
> We defend and demand a concept of "person" that is not linked to a certain set of abilities." (cited by Tremane Barr)

Genetic Discrimination And Genetic Privacy

As genetic testing becomes more widespread, there are concerns that health insurance and employability will be affected. Health insurance companies can currently charge higher premiums or refuse coverage if a person smokes, has pre-existing conditions or is a certain age. But risk based on genetics have advanced through molecular biology and it would be possible to deny insurance or employment on genetic predisposition.

> "Shall we then be able to identify some genes as weaker genes? If so, what shall we do to those who already have these genes? Who will decide which trait would make any of us unacceptable to the dominant majority? How will such a decision be made? Should such a decision be made? If such decisions are ever made, it could form the basis for doing away with those who would be dubbed "defectives" in order to improve society.
>
> What safeguards should be put in place to curb such well intended but disastrous enthusiasm in our future?" (Interview with Dr Stephen Sodeke)

Eugenics Today

For Indigenous Peoples eugenics gets blanketed into the term colonisation but eugenics policies and ideas have informed policies and practices that impact on Indigenous Peoples. What this section has done is to map some of the range of ideas that converge and form a range of social exclusions and terminations, called eugenics. In many ways eugenics are theories of fear which have the potential to become theories of hatred. The fears are grounded in the idea of being overwhelmed by 'the other' of being economically swamped by 'the other' - of being overpopulated by 'the other'. Eugenics has also historically become more overt when there are fears that dominant groups are weakening through lower birthrates, health concerns and other social factors. While this section has focused mainly on the theory and expression of eugenics overtly, there are wider implications not scoped here. That is the everyday commonsense expressions used by people and media, the talk about 'bloody Asians', 'Treaty gravy train', 'they're alright if they don't come near me' and other daily derogatory comments.

Within New Zealand there is very little that has been said about eugenics in the discussions about biotechnologies but both U.S literature and U.K literature make these links overtly. In some senses this section is a cautionary tale, for it explores the ways in which vulnerable or targeted groups in society can be potentially at risk in decision making about the 'fit' and the 'unfit'. Issues such as who should live and who should die, issues such as whether 'disability' is something to be eliminated, how disability is defined, the search for human perfection and other current issues arising in biotechnologies and in sterilisation programmes are some that are scoped here.

Eugenics in the broad sense is a story of how power creates knowledge. That is probably the most salient issue at present with the development of genetic technologies, which in turn raise issues around designer humans. There are a number of ways in which power culminates in knowledge, often covertly, through such practices as forced sterilisation, castration and internment, and also through policies of separation, exile and urbanisation."

Currently Maori birth statistics are rising and there is a concern over birth rates of others. Eugenics arose when immigration was considered a problem, when the underclasses were taking over, when 'population' problems emerged. What are the relationships of power that exist that emerge as a basis to eugenics ideas and what are the implications for already marginalised groups within states and in particular for Maori/Indigenous.

MAORI SEXUAL AND REPRODUCTIVE HEALTH WORKERS

PART THREE

Kaupapa Maori Model Of Reproductive And Sexual Health

In order to reveal what a kaupapa Maori model of reproductive and sexual health might look like, it is necessary to discuss the ways in which the Western model does not cater for it. The following analysis argues that it is important to analyse the western health model, to reveal some of the layers where power is asserted. That analysis has come at times from within the western philosophical tradition which this section will draw on. By unravelling the points at which power is asserted, this can inform the development of Kaupapa Maori health.

Medicalising The Body Philosophical Concerns For Maori

It is often said that Western medical science is reductionist and that its fit with Maori worldviews of wellbeing is precarious. There are a number of strata to the commercialisation of genetic material, for instance, especially as the Indigenous societies are being reduced to their various genetic levels. Aroha Mead ponders this type of reductionism:[149]

> "Instead of looking at a whole country and its territorial boundaries, one reduces the country to a grid of ecosystems (terrestrial biodiversity, marine and coastal, agricultural biodiversity, deserts, marshlands) and then further reduces those ecosystems to plant/marine species and then again to genetic resources of all living things within a state's territory. Each level of reduction presents an increased commercial opportunity".

However, precisely what reductionism as a methodology embraces needs further clarification. The tendency of Western medical science to expunge doubt – to pare life down to its smallest parts – has often been attributed to Descartes.[150] Descartes was a major contributor to the notion that the environment of the senses had to be discarded in order to gain knowledge. Descartes coined the famous maxim "cogito, ergo sum"[151]. From this maxim, a doubt/certainty dichotomy was brought into existence, and it is from this that Western medical science gains its ability to doubt the spiritual world.[152]

Health As A Mechanism For State Control A Foucauldian Illumination

It is a popular exercise to place the exorcism of the senses in a model of health solely at the feet of Descartes. However, Foucault places this phenomenon within a broader context and thus might illuminate a theoretical model to underpin another model of reproductive and sexual health. Foucault challenged the myth that the medical profession could engage in the disappearance of ill-health.[153] In doing so, he discusses the nature of the active Gaze and moves to describe how it is at the centre of medical/bodily encounters. Foucault states[154]:

> "The years preceding and immediately following the Revolution saw the birth of two great myths with opposing themes and polarities: the myth of a nationalised medical profession, organised like the clergy, and invested, at the level of man's bodily health, with powers similar to those exercised by the clergy over men's souls; and the myth of a total disappearance of disease in an untroubled, dispassionate society restored to its original state of health."

Foucault describes the frenzy within Modern West to divest itself of medieval superstition.[155] Ironically, the West did not manage to completely remove all myth; in fact, one of the greatest myths which was apparently introduced during this period was that doctors were wise. It was a myth, however, which would have huge consequences for power relations, especially those as between patient and doctor and which would remain until contemporary times.

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149 Mead, A. (1996). Cultural and intellectual property rights of Indigenous Peoples of the Pacific. In Pacific regional workshop on UN Draft Declaration. 4 Sept 1996. Suva, Fiji. Electronic document, accessed February 1, 2005. http://www.ubcic.bc.ca/docs/fiji.pdf, p.7.

150 Capra, F. (1982) The turning point: Science, society and the rising culture. New York, Simon and Schuster.

151 "I think, therefore I am."

152 Mika, C.

153 For further discussion on Postmodernist philosophy, see: Lyotard, J. (1993) The Postmodern Condition: A Report on Knowledge. (G.Bennington & B.Massumi, trans) Minneapolis, University of Minnesota Press.

154 Foucault, M. (1989) The birth of the clinic: An archaeology of medical perception. (Trans. A.Sheridan) London, Routledge, p.36

155 Callinicos, A. (1990) Against postmodernism: A Marxist critique. Cambridge, Polity Press.

Foucault also discussed the notion of surveillance in health models which was a direct reference to Bentham's Panoptican, a model prison.[156] Less about wellbeing than the maintenance of political power, surveillance was employed in hospitals to ensure that there were no abnormalities. The Gaze was therefore important in ensuring that there were no abnormalities in hospital wards. What emerges is a type of language which is bound up in an inescapable truth. Foucault warns us that hospitals can become major subscribers to the biopower of government. However, there is also an implicit and more fundamental warning for Maori – that the Gaze, with its dehumanising focus, may do more damage to Maori wellbeing than is at first apparent.[157]

Maori And The Gaze

As the person becomes the sexual illness, or the reproductive phenomenon, their collective identity may disappear; the world of truth alluded to by Foucault reduces the individual to a state where all that matters is their disease status. It does this through its inextricability with history and with the power of the State.

In a reproductive and sexual health model which attempts to reflect kaupapa Maori, critical analysis is absolutely vital. The process of critical analysis requires a number of steps: firstly, it should identify the subtle areas of colonisation in educational fora and in clinics. It should then engage in an in-depth analysis, often theoretical, of these areas so that their scope is recognised and their integration into the area. Thirdly it must have some viable, tangible outcome; at this point discussions around practices which mirror kaupapa Maori praxis should occur.

For instance it is assumed in Western society that greatest awareness comes about through enlightenment. This is often a belief embraced by Maori also. The term enlightenment is often related to the epoch of Enlightenment, of the Seventeenth Century when Descartes, Bacon and scientific knowledge were being illuminated, and there was a concomitant turning away from darkness and superstition. It is possible that the priority given to light is not a Maori one. In fact the dark, te kore and te po, is hugely important to the area of reproduction. Ranginui and Papatuanuku procreated in darkness[158]; their precedent can provide clear messages to workers in the area of reproductive and sexual health that there is a place for all states of being. Therefore an attempt to bring back to the fore those other states of being relegated by the West is significant to a kaupapa Maori model of reproductive and sexual health.

A Kaupapa Maori Model The Necessity For Spirituality

Maori are often cited as being 'holistic'.[159] Quite what this means needs some clarification, particularly as a holistic approach needs to be infused throughout a kaupapa Maori model. Central to the notion of kaupapa Maori is the element of whakapapa, which acts to bind everything within te ao Maori[160]. Writers of kaupapa Maori often explicate deeper functions of words so that they act more than mere labels; they also carry with them worldings which form a model of holism.

It is true that a holistic model incorporates notions of tapu and noa. Within these we see a complexity of interrelationships, which reside beyond the words. Tapu and noa are both states of being which can change instantly, reflecting the dynamic nature of iwi, hapu and whanau. The ability to allow for the constant change in states of being from one instant to the next is one which would underpin any kaupapa Maori model of reproductive and sexual health. This means that a Western notion of balance, in the sense that a state of being is maintained for long periods of time and must be kept in equal proportions to its opposite, is one that creates dualisms and is thus oppositional. Tapu and noa provide ways of looking at health, which acknowledge freedom from polarities and instead embrace the complexity of instant and multi-dimensional change.

156 Jay, M. (1986) In the empire of the gaze: Foucault and the denigration of vision in twentieth-century French thought. In D. Hoy. ed. Foucault: A critical reader. Oxford, Blackwell, pp.175-204.

157 Mika, C (2005) Western medical science and its normalisation of the Maori body (Unpublished thesis, Te Whare Wananga o Awanuiarangi).

158 See Smith, S. Percy. (1913) Te Kauwae runga: the lore of the whare wananga New Plymouth, Thomas Avery. He discusses the movement within darkness and time for the process of being. Not all writers agree with this interpretation however; see Barlow, C (1991) Tikanga Whakaaro: Key concepts in Maori culture United Kingdom, Oxford University Press, who describes darkness as "the seedbed of ignorance" (p. 94)

159 Durie M (1994). Whaiora. Maori Health development. Auckland, Oxford University Press.

160 Pihama, L. (2001) Tihei Mauri Ora: Honouring our voices PhD Thesis, Auckland, University of Auckland. See also Royal, T (ed) (2003) The woven universe: Selected writings of Rev. Maori Marsden Masterton, Living Universe Ltd.

Whakapapa As A Force For Wellbeing

It is therefore necessary to go beyond the perfunctory use of words when considering any kaupapa Maori health paradigm. As stated earlier, whakapapa has a meaning quite different from its English translation of 'genealogy'.[161] While genealogy is undoubtedly important within te ao Maori, whakapapa precedes names and has its origins in a spiritual cohesion which itself precedes human consciousness[162]. Maori may have given names to aspects of whakapapa but its complexity defies actual comprehension and scrutiny. Whakapapa bestows uniqueness[163] and so it also allows individuals and groups to undergo changes immediately. It may therefore be instrumental in providing healing for particular individuals.

It becomes clear that models which recognise the importance of immediate locality and space will be most efficient in providing healing in reproduction and sexuality. Sometimes it may be necessary to ensure that an individual is placed in a certain setting to ensure that their whakapapa can resonate with the mauri of that area. This may change immediately, however, and so it is important that people who can read the importance of whakapapa and its interrelationship with mauri are present to provide healing in a reproductive and sexual health setting. Thus 'body' and its apparent rendering 'tinana' are not the same:

> "While Western scientific and legal definitions of 'body' focus on corporeality, the body as 'tinana' is something that defies Western nomenclature. 'Tinana' as a mere physical construct is a misnomer; 'tinana', the embodiment of ancestral and descendant attributes, of spiritual bodies that are capable of flight, and mergence with other dimensions, is a creation of whakapapa. While there are physical aspects to 'tinana', its meaning, its sense, resist narrow definitions."[164]

Reproductive and sexual health would find its place in the recognition of the tinana as occupying a number of dimensions simultaneously and so not merely about 'inheritance', as the body is in English. It is important to note that words themselves carry with them particular worlds; one way of ensuring that appropriate worlds are referred to is to retain and use the appropriate words, or appropriate modes of communication.

Another element important within kaupapa Maori approaches to reproductive and sexual health is that of communication. This is not communication in the sense of unhindered lines of contact and expression, although this is important too. It is the ways in which communication takes place. Some Maori, for instance, may express concern that a makutu placed on their ancestors has prevented them from reproducing. What this means is that communication has been established between the spiritual force of that makutu and the present generations. Understanding that even makutu and disease are possessed of mauri means that communication may be established between the environment of that person and that particular mauri.

Any model of reproductive and sexual health needs to be aware of the lessons carried by art, waiata and other modes beyond written and linear oral forms. Art forms [168] and waiata contain reference to reproduction and sexuality which affirm whakapapa and its interrelating force.

Allowing Maori Diagnosis

Actual knowledge of whakapapa becomes important[165] when Maori who work in the reproductive and health areas search for ways to assess where the individual within their scope originates from. Ascertaining who they are and where their whakapapa links them to is crucial to this particular gaze. The process is crucial because it facilitates the movement of the individual to locations and people that may best assist in their healing process.

This has little to do with the gaze highlighted by Foucault. In fact Foucault warns workers in the reproductive and sexual health areas against viewing whakapapa as something that is merely a genealogy – as static and only capable of assisting in a genetic sense. On the contrary, we see that a fluid, dynamic approach to whakapapa prevents the normalisation process that

161 Pihama, L. (2001) Tihei Mauri Ora: Honouring our voices PhD Thesis, Auckland, University of Auckland.

162 Royal, T (ed) (2003) The woven universe: Selected writings of Rev. Maori Marsden Masterton, Living Universe Ltd. Marsden talks about the basket Te Aronui as that which carried whakapapa; he translates this as "before our senses."

163 King, M (ed) (1992) Te Ao Hurihuri: Aspects of Maoritanga. Auckland, Reed Books. Rangihau discusses the particularity of whakapapa.

164 Mika, C (2005) Western medical science and its normalisation of the Maori body (Unpublished thesis, Te Whare Wananga o Awanuiarangi) p46

168 For living examples of the retention of whakapapa knowledge through whakairo, see Mead, H (1986) Te Toi Whakairo Auckland, Reed Books

165 Knowledge of whakapapa is also important in retaining the names of ancestors within the memories of the living.

is inherent in the medical gaze. An acknowledgement and integration of this perception of whakapapa allows for a spiritual paradigm of reproductive and sexual health to thrive, where healing can be called in from a number of dimensions.

More Concrete Concerns

It can be seen from other sections of the report that separating out reproductive and sexual health from the rest of health has not occurred in Indigenous declarations relating to health. Reproductive and sexual health in these declarations is actually paired with political concerns and sits within a greater backdrop of colonisation and an attainment of wellbeing. A kaupapa Maori paradigm of reproductive and sexual health would likewise be reluctant to allow for a separation unless this approach could be sourced historically, or was traditionally necessary within the specific communities of individuals seeking help.

Similarly, a kaupapa Maori model may not concentrate on rangatahi in delivery of programmes. In working closely with other areas of health, there would be a need to look more widely at communities. Maori do not necessarily view rangatahi as being in greater need of help than other age groups. This is partly because they have different views around such issues as teenage pregnancy. Teenage pregnancy can be catered for within functional Maori communities; this may not be true, however, in urban settings but still there needs to be an emphasis on collective responsibility and a move away from focusing on the teenage parents.

This does not mean that rangatahi are not special in this domain; however, a closer fit with kaupapa Maori is afforded by an inclusive approach. The significance of this is that any advertisements should not focus on rangatahi as a 'problem'. Here there is a need for counter discourses around deficit theories. Reproductive and sexual health from a kaupapa Maori perspective would instead consider the place of key individuals within the communities of rangatahi, if possible, and not assume that it is merely the rangatahi that needs focusing on.

At this stage we encounter the wider issue of what counts as whanau. At present there are a number of interpretations of 'whanau', which are forming the bases for governmental research.[166] It is remarkable that there is increased Government interest in whanau research given the Government's insistence that Maori entities be called 'iwi' or "large hapu" before they participate in Treaty settlements, for instance[167]. Treaty settlement processes are vital to the outcome of reproductive and sexual health for Maori – or at least the processes' perceived outcomes are. For example the WAI 262 claim focuses on flora and fauna and resultant rongoa use, and its outcome has definite repercussions for reproductive and sexual health. Other claims have a part of their particulars as health grievances.

Constructions and interpretations of whanau lead to broader considerations around what constitutes tino rangatiratanga. Those working in the reproductive and sexual health arena who wish to pursue a kaupapa Maori model need to understand the vigorous and localised interpretations given to this term which has been largely defined legally. Communities will attach a plethora of different meanings to this term and so it is important for health workers to leave behind legal definitions, or indeed any static definitions, particularly in communities where the term has been hotly debated and practised. Even in communities where the term is not used, reproductive and sexual health models must recognise that tino rangatiratanga may be practised in all but name.

Tino rangatiratanga is necessarily addressed by key writers of kaupapa Maori. Leonie Pihama, for instance, refers to it as "an expression of Maori aspirations for self-determination, Maori autonomy, Maori sovereignty".[168] How Maori communities view tino rangatiratanga obviously impacts on how reproductive and sexual health services are delivered. Tino rangatiratanga may empower communities to take charge of their own models of reproductive and sexual health with varying degrees of assistance by Western advertising, medicine and education. A spectrum of this could exist where tino rangatiratanga allows communities to engage with mainstream services as needed.

Indeed there may be a variety of interpretations of any Maori terms. Again, 'whanau' provides an interesting example. Leonie Pihama describes the multi faceted nature of whanau, where whanau will never actually be 'family'. She recounts a point she made earlier:[169]

166 The Ministry of Maori Development has recently funded a number of research projects into aspects of whanau – Whanau Development Action Research Program.

167 The Office of Treaty Settlements website - http://www.ots.govt.nz/

168 Pihama, L. (2001) Tihei Mauri Ora: Honouring our Voices PhD Thesis, Auckland, University of Auckland.p. 127

169 Pihama, L. (2001) Tihei Mauri Ora: Honouring our Voices PhD Thesis, Auckland, University of Auckland.pp. 134-5

> "The limited definition of the 'family' as nuclear, heterosexual and constructed within limited gender roles is not 'natural', but is constructed by certain groups to benefit their own interests … For many people the definition of 'family' is not dependent on a legal contract of marriage, or is it dependent on the idea that family must be one man, one woman and their children. Such a definition is not only limited but it also imposes restrictions on how different groups wish to construct their families. With the nuclear heterosexual family being centred as the 'norm', the standardised version of family, everything else is measured against it and labelled and judged accordingly."

Orthodox readings of families mean that, despite legislation like the Civil Union Act, same-sex couples may not adopt a child under both parents' names. Hence the courts prevent whanau from flourishing, and make particular behaviours acceptable and others not permissible. In terms of reproductive health, then, colonisation has affected many Maori to the extent that whangai are often viewed as something less than biological children. In other situations children in families are treated according to whether they behave within conformist paradigms – including, in a colonised epoch, whether they have married before pregnancy, whether they have sustained a relationship with their opposite sex partner and so on.

This flows through to succession to land and an individual rights' focus. Indeed the individualisation of land titles of the Nineteenth Century has itself had an impact on reproductive health in the sense that whanau, hapu and iwi were redefined – sometimes in name but more often according to physical boundaries and then conceptually. Kaupapa Maori models of reproductive health would demand that these impacts, and more, are identified, recognised and mediated accordingly. For instance, differing forms of whanau should be celebrated and not subject to normalising practices simply because they are non-Christian, not legislated for or unorthodox.

Tensions Within Kaupapa Maori Organisations

Tensions exist also in the sheer practical implementation of kaupapa Maori models of any form. Obviously kaupapa Maori models are hindered by policy and legislation; it often takes great amounts of effort, money and sometimes legal intervention to try and allow space for kaupapa Maori within mainstream models of health. Being forced to comply with legislation can spark the beginning of significant tension; views will differ in an organisation as to whether the legislation should be challenged, who should be challenging it (including who has the right to challenge it), to what extent it should be challenged, and how much intellectual property should be revealed in challenging it. Often kaupapa Maori organisations will survive these kinds of tensions but sometimes they do not, particularly if a strong foundation has not been established for the organisation from the outset. In the context of reproductive and sexual health a sturdy foundation might be ensured through a shared vision of what constitutes reproductive and sexual health, which should be informed through the hapu in which the organisation is operating and its physical and spiritual environment. For instance, basic discussions around whether sexual health is necessarily focused on sex are important; what specific hapu and iwi based birth practices were; and how credible are particular kaumatua *really* in dealing with reproductive and sexual health issues.

Other tensions also can emerge. The extent to which non-Maori speakers can participate in reproductive and sexual health models is likely to figure. The experience of the writers is that many tensions return to whether Maori, who cannot speak Maori, should be allowed to make decisions. Clearly many Maori cannot speak Maori but have particular gifts and abilities anyway which are pivotal to hapu based reproductive and sexual health models. Space needs to be made for these people in kaupapa Maori models of health.

Similarly conflict can arise around whether outsiders should be allowed to participate in the delivery of reproductive and sexual health services to local Maori communities. While there may be resistance to this, on the grounds that they are not related to stakeholders, often some organisations are grateful for the participation of outsiders, particularly in cases where there is a strong emphasis on privacy and confidentiality. Many Maori may be reluctant to attend a clinic, for example, where their relation works. However an outsider can provide the same care service and allow for the person attending the clinic to be more at ease.

Some organisations may advocate a less stringent approach to confidentiality and privacy; obviously all organisations are required to adhere to the provisions of the Privacy Act and so are legislatively barred from disclosing personal information about their stakeholders. Some kaupapa Maori models of reproductive and sexual health may see a need for greater sharing of information if the need arises; tensions between this and legislation are obvious.

Although there is a growing acceptance of Western trained specialists in general, there still remains a certain reluctance to allow them to return to locally based organisations. In fact the phenomenon of Maori trained to qualification stage creates a dichotomy amongst Maori communities, with some individuals being adamant that their expertise is needed and others remaining suspicious of their intentions and education. In a similar fashion, those who establish kaupapa Maori organisations are often completely different to others who join at a later stage. Those who establish the organisations create the initial vision, desperately search for funding for the organisation, and operate the vision but often for very little pecuniary gain. Latecomers to the organisation enter a very different scenario, in which they can be salaried and resourced. Many fear that, with the change in access to resources, the vision will also change, particularly under those who are educated in the mainstream.

Conclusion

In the first instance, kaupapa Maori models of reproductive and sexual health need to be cognisant of the different strands of Maori existence. This is what allows them to operate within a Maori epistemological framework and distinguishes them from a Western, mainstream approach. While there may be a need to draw on the mainstream, kaupapa Maori approaches demand a process of critical analysis first, to ensure that a colonising model is not being unwittingly replicated.

Strands of Maori existence sit within an understanding and allowing of spiritual energies, discussed at length by such writers as Pere.[170] The spiritual dimension has to be allowed because it is that which justifies our description of ourselves as holistic. Thus the spiritual dimension transcends the use of words; it is the world within the words that becomes important. Even such words as 'ira', often translated as 'gene', arguably occupy a world completely different to that of 'gene'.[171] Hence kaupapa Maori models of reproductive and sexual health necessarily grapple with, and constantly revise, frequently used terminology.

Foucault in Birth of the Clinic brings to our attention the dangers inherent in the use of terminology to describe illness, and, upon extension, of reproductive and sexual health. He sees the terminology as being linked to notions of 'truth' and state power, complicit as they are with Enlightenment visions of progress. Therefore the need to unwrap the layers of meaning within hapu based words for reproductive and sexual health, if they exist, is necessary. Although some of the tensions which appear in kaupapa Maori organisations generally may appear insurmountable, in fact with a clear philosophy and a revisionist approach they can be successful in dealing with the needs of Maori in the area of reproductive and sexual health.

170 Pere, R (1991) Te wheke: a celebration of infinite wisdom. Gisborne, Ao Ako Global learning

171 http://www.tki.org.nz/r/science/curriculum/p104_114_m.php - Te Tahuhu o te Matauranga website

MAORI SEXUAL AND REPRODUCTIVE HEALTH PROVIDERS

PART THREE A

Maori Sexual And Reproductive Health Providers

Within the Ministry of Health organisational structure, sexual and reproductive health is administered in different areas. The Public Health Directorate funds contracts for PHO's and other service providers. The Ministry of Health funds District Health Boards, who provide funding for sexual and reproductive health contracts to DHB service providers.
The Ministry also has a small unit focusing on Sexual and reproductive health, concentrating on providing policy advice to the minister and managing sexual and reproductive health campaigns and contracts.

In relation to sexual and reproductive health service in New Zealand, there are a number of mainstream sexual and reproductive health service providers, including:

Family Planning Association, including Family Planning Association International Development (FPAID);
Family Life Education Pasefika (FLEP);
Sexual health clinics and laboratories;
Fertility Clinics;
New Zealand AIDS Foundation;
GPs/Hospitals.

Maori Health Providers may also be contracted to deliver sexual and reproductive health service.

> "Maori health and disability providers deliver services that target Maori communities or clients. They are also delivering services to the wider population and may also be delivering other social services like housing, budgeting, legal and environmental quality consultancy. The service provider is led by a Maori governance and management structure and expresses a Maori kaupapa (vision or purpose). Maori health providers tend to incorporate consideration of the wider issues of Maori development and these might apply to their own organisations. Our role in relation to Maori providers is to encourage innovative and more effective approaches to specific health and disability issues."[172]

At present there are 240 Maori Health Providers who are contracted to 21 District Health Boards.[173] There are few Maori Health Providers offering sexual and reproductive health service in New Zealand. Some sexual and reproductive health service providers are contracted directly with the Ministry and others are contracted through District Health Boards.

The only Maori Health Provider that specifically focuses on sexual and reproductive health is Te Puawai Tapu. Te Puawai Tapu is a kaupapa Maori sexual and reproductive health service provider specifically concentrating on sexual and reproductive health, offering education and awareness programmes for schools, health provider training, and producing kaupapa Maori research and policy advice for the Ministry of Health and government. Te Puawai Tapu and the Conference Advisory Group hosted the 1st National Maori Sexual and Reproductive Health Conference held at Wainuiomata Marae, Wellington, on Monday 1 November 2004.

A host of recommendations resulted from the 1st National Maori Sexual and Reproductive Health Conference, for a National Working Group to present and discuss with the Ministry of Health for the future development of the Maori sexual and reproductive health sector:

> "<u>Sector Development</u>
> Explore options to lodge a claim to Waitangi Tribunal regarding Crown failure to ensure equitable outcomes for Maori in sexual and reproductive health
> National Working Group (role is strategic planning, implementation and monitoring of Maori sexual and reproductive health)
> Regional Maori sexual and reproductive health networks (linked to National Working Group)
> National website
> National Maori research and evaluation 'agenda'
> <u>Services Development</u>
> Maori sexual and reproductive health as one of the ten Maori health priority areas Priority funding and development for 'by Maori, for Maori' organisations

172 Maori Health website, visited 26 October 2006: http://www.Maorihealth.govt.nz/moh.nsf/pagesma/326

173 Maori Health Directorate, http://www.moh.govt.nz/moh.nsf/menuma/Maori+health+providers?Open. Visited 16 November 2006.

'Stock take' by volume, type, location of sexual and reproductive health services for Maori (both 'by Maori, for Maori' and general population services)
High-quality, comprehensive national sexual and reproductive health data-set, and data analysis based on disparities
Comprehensive Maori sexual and reproductive health contracts (linking clinical and health promotion contracts in sexual health, and ensuring links to cervical and breastscreening services)
'Long-run' contracts
Contracts that reflect the higher development costs in Maori sexual and reproductive health
Workforce Training and Development
More Kaupapa Maori sexual and reproductive health education, promotion and clinic services
Nationally-certified Kaupapa Maori sexual and reproductive health training (not FPA New Zealand-type training)
Training for rangatahi educators working with rangatahi (including working in wharekura, using te reo Maori medium)
Training for educators working with parents and whanau."[174]

There are other Maori Health Providers in the different regions throughout New Zealand who offer sexual health or sexual and reproductive health as a part of their total health service provision.

Towards the end of 2003, Te Puawai Tapu conducted a sector profile of the Maori sexual and reproductive health workforce for a Maori sexual and reproductive health workforce development forum, hosted by the Public Health Directorate of the Ministry of Health. The forum was held on 19 November 2003 with representatives from the Ministry of Health and representatives from Maori sexual and reproductive health service providers. "The purpose of the Forum was to explore the need for Kaupapa Maori sexual and reproductive health workforce development in these organisations. The goals of the Forum were to:

- Identify key Kaupapa Maori sexual and reproductive health workforce issues;
- Develop strategies for addressing priority issues;
- Foster and promote a network for ongoing exchange of training, resources and support between Maori staff providing Kaupapa Maori sexual and reproductive health services."[175]

Because Te Puawai Tapu has completed the only survey that we are aware of that has been conducted on Maori sexual and reproductive health service providers, it is important to include the survey report here, and the discussion of the survey report that took place at the Maori Sexual and Reproductive Health Workforce Development Forum on the gaps in the current service delivery, and the skills and workforce required to fill these gaps.[176]

174 1st National Maori Sexual and Reproductive Health Conference. Conference Proceedings. Conference Advisory Group. Te Puawai Tapu. Wellington, 2004. Page 33.

175 Maori Sexual and reproductive health Workforce Development Forum, hosted by the Public Health Directorate of the Ministry of Health, held on 19 November 2003 at the Minstry of Health, Wellington.

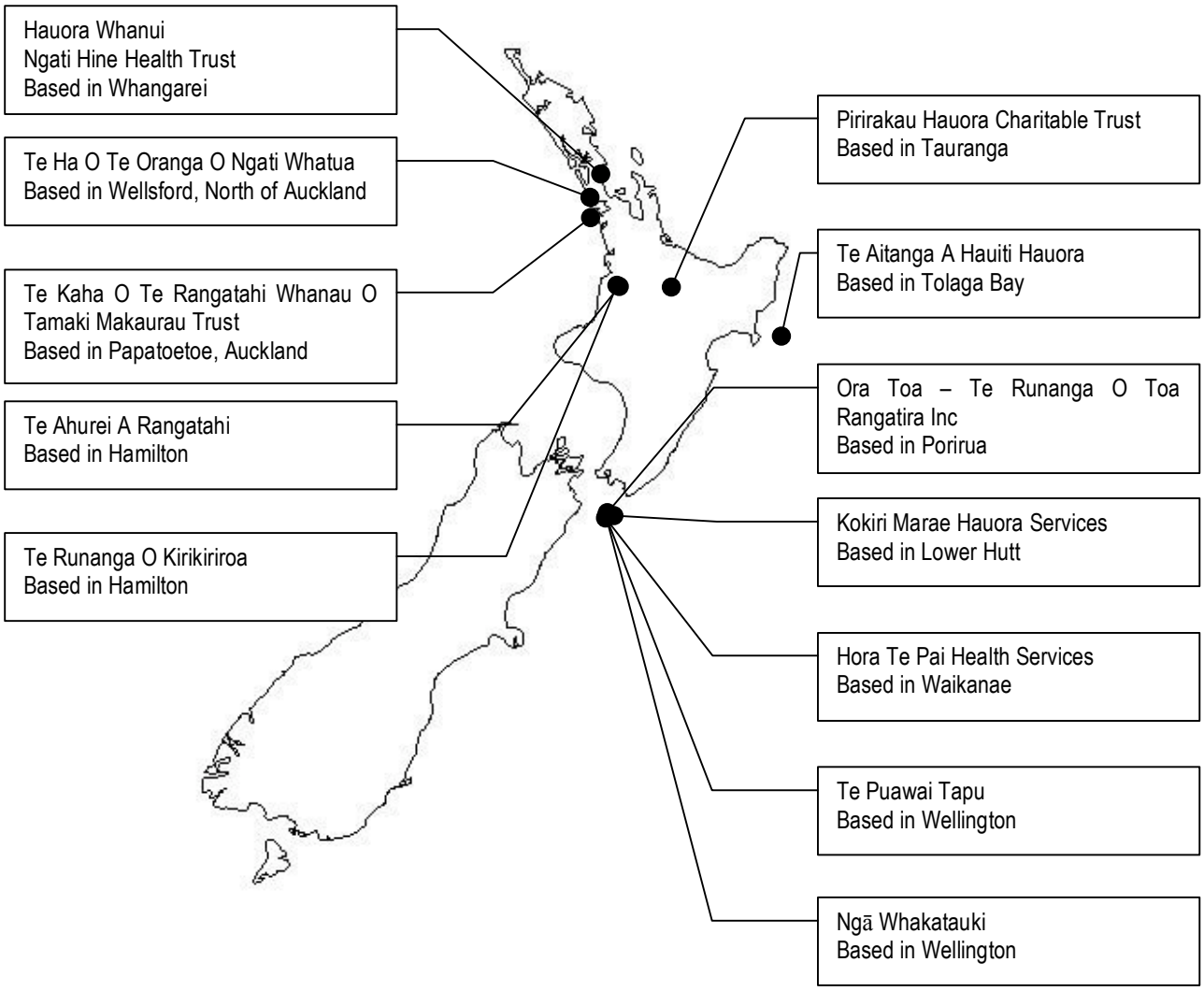
176 Prior to the Forum, a questionnaire was developed and distributed to all 14 Kaupapa Māori organisations in New Zealand that have specific sexual and reproductive health contracts. The Ministry of Health made the decision to exclude organisations that have Whanau Ora contracts that include a sexual and reproductive health component, and 'mainstream' organisations that employ Maori staff to provide sexual and reproductive health services to Maori.

The Workforce Now: A Sector Profile[177]

1. Profiles Completed

- 14 organisations were sent profile questionnaires
- 11 organisations completed and returned the profile questionnaires

2. Kaupapa Maori Organisations Providing Sexual And Reproductive Health Services To Maori



177 Ibid.

3. Organisation Service Contracts

- 1 organisation is contracted to provide only sexual health services (sexuality education, promotion, information, policy, advocacy, training and research services);
- 10 organisations are contracted to provide a mixture of sexual health education, promotion or clinical services, in addition to a wide range of other primary health services;
- Of the 10 organisations, 3 are contracted to provide sexual health clinical services, but one of these does this by subcontracting to local Sexual Health Services;
- 1 organisation has a training contract, although two organisations provide training; organisations have research contracts, but neither contract is with the Ministry of Health or DHB.

4. Type Of Sexual And Reproductive Health Services Delivered

TYPE OF SERVICE	NO OF ORGANISATIONS
Clinic services	3
Sexuality education	7
Sexual health promotion	6
Policy and advocacy	1
Training	2
Research	2

5. Service Coverage

Most organisations provide sexual and reproductive health services across potentially large geographical area, despite the small size of services.

6. Sexual And Reproductive Health Service Size By FTE's

ORGANISATION	FTE
Hauora Whanui - Ngati Hine Health Trust	1.0
Te Ha O Te Oranga O Ngati Whatua (No FTE detail as subcontract clinic services to Sexual Health Services, Auckland DHB)	Unknown
Te Kaha O Te Rangatahi Whanau O Tamaki Makaurau Trust	3.0
Te Runanga O Kirikiriroa (Delivered as **part of 1.0 FTE** asthma, hearing loss prevention, immunisation, parent support and motor vehicle injury prevention)	1.0
Te Ahurei A Rangatahi	4.0
Te Aitanga A Hauiti Hauora	1.5
Pirirakau Hauora Charitable Trust	1.0
Ora Toa – Te Runanga O Toa Rangatira Inc (No FTE detail as delivered as part of GP services)	Unknown
Kokiri Marae Hauora	1.5
Hora Te Pai Health Services	1.5
Te Puawai Tapu	8.5
TOTAL FTEs (Full-Time Equivalents)	23.0[178]

178 Includes 2.25 FTE Research, funded by Health Research Council of New Zealand.

7. Clients

Maori Rangatahi, adults and whanau in schools, marae, Maori health centres and community settings in urban (5), semi urban (4) and rural (2) areas.

8. Recruitment - Difficulties

It is very difficult to recruit Maori staff who already have specialist sexual and reproductive health skills, and almost impossible to recruit Maori staff with the combination of specialist sexual and reproductive health skills and Kaupapa Maori skills

9. Retention - Difficulties

Staff turnover in most organisations providing sexual and reproductive health services is reasonably high. Reasons for this are given as career advancement, study, and personal reasons, in that order

10. Sexuality Education And Promotion – Minimum Entry-Level Qualifications

- Experience working with Rangatahi Maori
- Experience in performing arts
- Te Reo Maori/Tikanga Maori
- Good communication and good people skills
- Up to 30 years old
- Teaching qualifications for Senior Sexuality Educators

11. Sexual Health Clinics – Minimum Entry-Level Qualifications

Registered Nurse

12. Training Provided 'In-House' By Organisations

- Induction
- Te Reo Maori/Tikanga Maori
- Networking
- Programme Planning
- Maori Models of Health
- Whakawatea (Decolonisation Maori Training)
- Kaupapa Maori Sexuality Education Training

13. Training Obtained From Other Organisations

- Specialist 'medical' sexual health training provided by Sexual Health Services and/or FPA New Zealand
- Kaupapa Maori sexuality education training provided by Te Puawai Tapu

14. Training Needed But Not Available

- Specialist 'bio-medical' sexual and reproductive health training
- Resource development training (ie information sheets, teaching resources for classrooms, etc)
- Training in secondary school Health Curriculum
- Health Promotion in general, including on HIV/AIDS
- Sexuality education training for youth educators and health promoters
- Health promotion programme development training

15. Other Workforce Issues

- Want training / workshops on Kaupapa Maori and/or Maori models of sexual health
- Review of current programmes to ensure information provided in classrooms, etc is up-to-date
- Want up-to-date data / statistics on Maori sexual and reproductive health, and health behaviour
- Want NZQA-approved Maori sexual and reproductive health training
- Want Kaupapa Maori resource development
- Want more Kaupapa Maori sexual and reproductive health research to guide programme development and delivery
- Want career pathway in Kaupapa Maori Sexual Health
- Want more 'by Maori, for Maori' clinical services
- Want more Kaupapa Maori resources and information for Maori communities about sexuality and sexual health
- Want regular National Conference in Maori sexual and reproductive health to share knowledge and resources
- Want funding targeted to sexual health education and promotion."[179]

The gaps in the current service delivery, and the skills and workforce required to fill these gaps were discussed at the Maori sexual and reproductive health Workforce Development Forum after the survey report was presented by Alison Greene of Te Puawai Tapu. The main conclusions resulting from this discussion were:

Gap Identification:

- "The Report '*The Workforce Now' – A Sector Profile* illustrates how small the Kaupapa Maori sexual and reproductive health sector is in comparison to the 'mainstream' sector. Most of the Kaupapa Maori organisations with sexual and reproductive health contracts have fewer than 40 hours per week available for sexual and reproductive health service delivery. This means that it is difficult for these organisations to specialise in sexual and reproductive health, and to justify staff training and service development and resource costs;
- Current contracting in sexual and reproductive health is disjointed i.e. clinical services are separated from health education and promotion-type services. Kaupapa Maori organisations want an opportunity to provide integrated sexual and reproductive health services, and to make these more whanau-orientated where this is appropriate. The ideal for Maori communities from an 'access' point of view is for these services / contracts to mesh together e.g. well women – cervical screening – breast screening – sexual and reproductive health education programmes – sexual and reproductive health clinical services;
- Kaupapa Maori organisations require funder assistance to encourage PHO's, for example, to contract for Kaupapa Maori sexual and reproductive health education and promotion services and clinical services from existing Kaupapa Maori service providers, and to utilise PHO access funding and health promotion funding to enable this to happen;
- Clinical contracts are funded based on the number of face-to-face 'one-to-one' visits. There needs to be the scope in contracts to allow for funding to support 'whanau' clinic visits in order to educate and empower whanau i.e. rangatahi and whanau visits to doctor about contraception;
- Kaupapa Maori organisations need funding and support to develop Kaupapa Maori sexual and reproductive health services, and associated service benchmarks. Kaupapa Maori organisations are left to do this developmental work themselves, without any additional funding, without the benefit of access to research, and without the support of other Maori working in the sector."[180]

The Workforce In Five Years:

- "Kaupapa Maori organisations should be supported to deliver a greater percentage of the sexual and reproductive health services required by Maori communities (i.e. current disparity of 23 FTE in Kaupapa Maori organisations vs 400+ FTE in non-Maori organisations should be reduced);
- Kaupapa Maori organisations should be funded at the same price per FTE as non- Maori organisations (e.g. current disparity of $45K for FTE's in Kaupapa Maori organisations vs $70K for FTE's in non- Maori organisations should be removed);
- Evaluate the Kaupapa Maori services (i.e. programmes) currently being provided, and grow those services that are working well for Maori communities;

179 Maori Sexual and reproductive health Workforce Development Forum, hosted by the Public Health Directorate of the Ministry of Health, held on 19 November 2003 at the Minstry of Health, Wellington.

180 Ibid.

- Based on the fact that many Maori prefer to access health from Maori organisations it follows that Kaupapa Maori organisations providing sexual and health services should be viewed by the funder as having 'preferred provider' status over non-Maori organisations providing sexual and reproductive health;
- Maori sexual and reproductive health should be a priority in District Health Board (DHB) plans because Maori sexual and reproductive health is in crisis;
- Kaupapa Maori sexual and reproductive health workforce development should be a priority for all health funders (DHB's, MOH and Clinical Training Agency) in order to develop a larger, more skilled Maori health workforce. The lack of a skilled workforce is a key factor limiting the growth of Kaupapa Maori sexual and reproductive health services."[181]

Three Priority Strategies For Building The Workforce:

- "**Continuation of Forum**: An immediate requirement is for funds to enable this Forum to continue to meet. The Forum provides a starting point for Kaupapa Maori organisations working in sexual and reproductive health to strengthen their networks with each other, share successes, share training, information and resources, and develop and articulate key messages about workforce needs, and solutions, to funders;
- **Service Funding**: An immediate requirement is for funding to support existing Kaupapa Maori workforce development initiatives (i.e. staff training programmes) and Kaupapa Maori sexual and reproductive health services, given the current disparities and need;
- Promotion of Kaupapa Maori sexual and reproductive health Issues
- The Forum mandates Te Puawai Tapu to articulate key sector issues to funders, to Ministries and similar organisations related to Kaupapa Maori sexual and reproductive health workforce development. Te Puawai Tapu is invited to take up this role as it is the only one of all 14 Kaupapa Maori organisations that has a national policy / advocacy contract and is, therefore, funded to undertake this role."[182]

Other Organisations Providing Sexual And Reproductive Health Services To Maori

Since the completion of this survey of the Kaupapa Maori organisations providing sexual and reproductive health services to Maori, there are a number of other Maori Health Providers that have self-identified themselves as offering sexual and reproductive health service provision in the Maori Health Providers section of the Maori Health website,[183] as well as others that have been identified through internet searches.

ORGANISATION	LOCATION
Arai te Uru Whare Hauora	Dunedin
Te Roopu Tautoko ki te Tonga	Dunedin
Araiteuru Whare Hau Ora	Dunedin
Te Hauora O Te Tai Tokerau	Northland
Nga Kaimahi ō Te Po	Wellington
Kahungunu Health Services	Hastings
Te Hauora ō Turanganui A Kiwa (Turanga Health)	Gisborne
Te Manu Toroa	Tauranga
Raukawa Trust Board	Tokoroa
Te Aronga Hou Inaianei	Auckland

Sexual and reproductive health provision is also undertaken through the District Health Boards (DHB) directly, and/or the DHB's will contract out the sexual and reproductive health service provision. Each District Health Board has implemented a sexual and reproductive health plan in some form.

A cursory internet survey of the District Health Boards that have readily identifiable sexual and reproductive health provision in their regions revealed a variety of sexual health and sexual and reproductive health services being offered by different specialist providers, as well as incorporation in District Health Board Strategic Plans and District Annual Plans.

181 ibid.

182 ibid.

183 Maori Health website, visited 18 October 2006. http://www.Maorihealth.govt.nz/moh.nsf/pagesma/174?Open.

In the 2003 Ministry of Health publication, "Sexual and reproductive health: A resource book for New Zealand health care organisations," the Ministry outlines suggested strategies for reducing health inequalities that District Health Boards (along with primary health care providers, health professionals and whanau) may action in order to contribute to improving Maori sexual and reproductive health provision. Specific DHB level Ministry suggestions include: working in partnership with Maori (iwi, hapu, whanau and community groups) to develop strategies; involving Maori in all aspects around service; ensuring at least the same level of health for Maori as non-Maori; ensuring Maori provider development; and enabling easy service access and responsiveness for Maori.[184] Other Ministry suggestions include: being aware of the wider influences on Maori sexual and reproductive health by initiating an intersectoral working group led by Maori; providing opportunities for the development of specific Maori health promotion resources; ensuring data collection provides a clear picture of the evidence of inequalities, and monitors changes; and "Increasing the capacity of 'by Maori for Maori' sexual and reproductive health services will enable Maori to access sexual and reproductive health services from local Maori service providers. It is important that by Maori for Maori provider groups have the same opportunities for training and upskilling as other health professionals."[185]

The Hawkes Bay District Health Board has just recently (November 2006) advertised for a Sexual Health Strategy Project Coordinator to help implement their Sexual Health Strategy, which was approved by the HBDHB in May 2006. "The strategy will improve access to school based services and early intervention services particularly for youth…The project will be a success if: Youth know where to access contraception and STI services. The new services are delivered in a safe, private environment that is acceptable for youth. Stakeholders support the new services to be successful and communication improves. Stakeholders feel that the service changes have been effectively and fairly managed."[186] The sexual health strategy will have a sexual health strategy project coordinator, who also works alongside a project steering group and an advisory group made up of sexual health professionals and the Hawkes Bay DHB Maori Health Manager.

The Counties Manukau District Health Board sees sexual and reproductive health as a priority area in their strategic plans and district annual plans. Dr Catherine Moor, Public Health Medicine Registrar, authored the 2004 report, "Sexual & Reproductive Health Issues, Programmes and Services in Counties Manukau: A Profile and Proposed Action Plan." Dr Moor proposes in her report an action plan for Counties Manukau DHB that is informed by consultation with stakeholders, review of health statistics in the Counties Manukau area, and review of the literature. Counties Manukau are significantly impacted by the high incidence of some sexual and reproductive health issues, such as teenage pregnancy, gonorrhoea, chlamydia, pelvic inflammatory disease, ectopic pregnancies. These issues significantly affect Maori, Pacific, and Asian communities living within Counties Manukau.

The proposed action plan for Counties Manukau included:

- Improve access to services;
- Enable workforce development and training, including, "Considering scholarships to allow Maori and Pacific members of the health workforce to upskill in community sexual and reproductive health provision"[187];
- Improve the quality of services, including, "Encouraging providers to ensure the acceptability of their services is maximised for young people, Maori and Pacific and Asian peoples"[188];
- Facilitate the prevention of adverse health outcomes;
- Wrapping preventative/health initiatives around the proposed school-based Pacific Teen Parent Unit;
- Improve local governance of sexual health services.[189]

In the report, "Counties Manukau Population Health Indicators 2005, 3rd edition," sexual and reproductive health issues affecting the Counties Manukau catchment area are summarised.

> "Teenage birth rates have been consistently much higher in CM than for the rest of the Auckland or nationally. Rates of sexually transmitted disease, pelvic inflammatory disease and ectopic pregnancy, all markers of unprotected intercourse are high in CM. Survey data backs this up, indicating about half of sexually active South Auckland secondary school students don't consistently use contraception when having sex. Maori and Pacific teenagers have higher rates than European or other groups in most of the indicators measured. With a pregnancy rate of around 12%

184 Ministry of Health (2003). "Sexual and reproductive health: A resource book for New Zealand health care organisations." Page 30.

185 Ibid, page 36.

186 Hawkes Bay District Health Board Position Profile, Sexual Health Strategy Project Coordinator, 10 Ocober 2006.

187 Dr C. Moor, Counties Manukau District Health Board. (2004). "Sexual & Reproductive Health Issues, Programmes and Services in Counties Manukau: A Profile and Proposed Action Plan." Page 5.

188 Ibid.

189 ibid, page 6.

for Maori teenagers, coupled with the high exposure to infection with unprotected intercourse Maori young women are at particular risk. While HIV rates are relatively low in our community, the high rates of chlamydia and increasing gonorrhoea rates are indicators we cannot ignore. Teenagers of European/other extraction are far more likely to seek a termination if they fall pregnant –over half did so in 2004, compared to a quarter of Pacific and a sixth of Maori."[190]

Providers Talking

Twenty interviews were completed with Maori sexual and reproductive health educators, nurses and administrators. We interviewed both mainstream workers and Maori providers. Because the provision of services is so patchy, many areas have no Maori delivery at all in the sexual and reproductive health area and those that are around are urban. All those we spoke to were focused on youth services.

It is readily apparent that the concerns, issues and resulting recommendations from Maori sexual and reproductive health service providers have not changed over time; including the completion of the 2003 Workforce Sector profile and accompanying Maori Sexual and Reproductive Health Workforce Development Forum, and the 1st National Maori Sexual and Reproductive Health Conference held in November 2004.

Maori sexual and reproductive health service providers we interviewed discussed similar concerns and issues that were raised in the 2003 and 2004 forums. We have therefore decided to include in this section blocks of quotes from Maori sexual and reproductive health service providers as we thought it important, and more potent, to articulate their concerns in their own voice.

The interviews contain layers of information of importance. With so little written by Maori about sexual and reproductive health, we regard these interviews as being of huge importance as they articulate work by providers, success factors, barriers and limitations, the context of their work, the nature of contracts and funding, educational programmes, advice to other educators, and information on nurses, clinics and STI's.

The detail of the interviews has been left in, rather than edited heavily because as a Kaupapa Maori project we wanted the voices of Maori working in the field to be prominent. Whilst this makes for lengthy reading, which some people may skip over, the detail of the information is not lost.

Because of the lack of consistency of delivery across the motu and the different capacity and resourcing, the issues raised in the report obviously cannot be generalised across all regions. There is also a wide diversity to what District Health Boards are doing, what public health provision there is, what schools are doing, what interest there is from health professionals, what awareness there is of sexual and reproductive health issues generally. What we did pick up in the interviews is the best-case scenario in terms of provision to Maori. It has to be realised that in the vast majority of cases there is no provision for Maori by Maori when it comes to sexual and reproductive health services.

Each Maori provider that we spoke to had developed quite differently, according to the issues of expertise available, philosophy, training they had done, the types of support available etc. Some were part of hauora/health organisations and some were part of youth providers. There are huge gaps in provision and delivery.

Te Puawai Tapu

Te Puawai Tapu was the first kaupapa Maori provider of sexual and reproductive education services. Emerging from Family Planning, Te Puawai Tapu had their origins in a taha Maori approach and it was later that the organisation evolved into a Kaupapa Maori organisation. Te Puawai Tapu was set up in 1990. Papaarangi Reid, Pania Ellison, Irihapeti Ramsden, Ani Delamere were all involved in the establishment of Te Puawai Tapu. According to one interviewee it took ten years to bring Te Puawai Tapu out from the New Zealand Family Planning Association (FPANZ). They had set up the organisation inside FPANZ because they were following Irihapeti Ramsden's model of parallel development. In 2000/2001 the two organisations were still linked at both governance and at an organisational level. At the governance level, both organisations shared governing members across their organisations. So TPT provided two people through to the Executive Council of FPANZ and

190 Counties Manukau District Health Board. "Counties Manukau Population Health Indicators 2005, 3rd edition." Page 134.

FPA provided two people to Te Puawai Tapu Executive Committee. An Incorporated Trust was established and Te Puawai Tapu became fully independent at the end of 2002.

One interviewee talked about how the establishment of Te Puawai Tapu was challenged by both Maori and Pakeha:

> *I think that's why the likes of Pania Ellison, Irihapeti Ramsden, Ani Delamere and Dr Papaarangi Reid, why they are pioneers in this area is because they really challenged not only mainstream organisations but also Maori thinking because we were quite comfortable to say, 'No, sexual stuff is taputapu, don't go there, don't talk about that.' So as a result they faced challenges on both sides of the fence.*

Focusing On Youth

The major focus for sexual and reproductive health is on youth and peer education. The shape and form of organisations and programmes has been in response to what funding can be obtained e.g Ministry contracts or DHB funding. Also most of the educators are urban, they are coming up with urban solutions. The development of peer education has been one of the key tools used for sexual and reproductive health. Te Puawai Tapu had attempted to get funding for adults programmes but were unsuccessful.

> *I think youth do get a lot of input because they are seen as you know, our future and all that kind of thing. But, it also feeds into this societal thing that youth is sexy and anything older is not. And I don't agree with that, and in some ways it invisiblises our sexuality and sexual and reproductive health in older populations. I think it also feeds into the thing that sex is everywhere but, it's nowhere. The original intention was for Te Puawai Tapu to have a service whereby adults worked with adults, and youth worked with youth. So, still following the peer education model but, it was the funders who in the end who wanted the youth.*
>
> *Our vision is to have young people making these decisions, making informed decisions and determining their tino rangatiratanga or, their own destinies. And, our mission toward that vision is supporting them through various projects and various mediums and vehicles through peer education. So, we have young staff delivering information and educational sessions, information to schools, to kura, to wharekura, to kura kaupapa, alternative education, tertiary institutions, community groups.*

One provider had six peer educators working with both Maori and Pacific.

> *We are a Maori organisation which provide sexual health services. Our aim, our target is our rangatahi. There's a team of six and we go into schools. We go into courses, alternative learning centres. We also do health promotion at health events. That's one of the services. We mostly target junior schools so, that's year nine to year ten. We run an eight session programme which, has just recently been revamped. We have another service is our sexual health clinic, and we have a doctor from FPA that comes in. And, that's for our young people and anyone who needs tautoko and support you know, doctors advice, peer support, contraception, condoms, STIs, all that. And, the other one is our antenatal clinic. And, that's where we have a midwife that comes in. And, we also have antenatal classes for our young mums to be. We cover a huge area, the whole of the city.*

For some sexual and reproductive health workers they are part of multiple services on one site.

> *We have a number of services, smoking cessation asthma training . We have social services which include a number of things like PAFT, Parents As First Teachers. They also have Insulating Homes in the area. Gosh, there's heaps of stuff. We have the Clinic downstairs.*

Some groups of sexual and reproductive workers are based inside other services. In this case a wider marae based health service, offering a wide range of services under the one roof. While offering a range of health services they also had workplace policies that reflected their focus on health and wellbeing:

> *We have lots of programmes. We have nga tane for healthy lifestyles for men. We also have a nutrition team with diet and exercise. We're not allowed any food that would be considered contraband. So, we have to eat healthy. The Ministry of Health have asked us to set up this nutrition thing. So, we have to abide by it, you know having that policy within our Hauora, and ensuring that we abide by it.*

One rangatahi Maori provider covers the whole Auckland area. One third of the NZ population in Auckland is served by one Maori youth provider. They raise key issues such as a lack of literacy among rangatahi of terms such as contraception.

I think we are the only Maori Sexual Health Peer Education Team in Auckland. And, then our brothers and sisters are only in Hamilton which is Te Ahurei o Rangatahi, and then Te Puawai Tapu in Wellington so, we all have a cool connection. You know, us three organisations in terms of that.

Another provider in Auckland deals with whakawahine:

The organisation was founded about 1990 but was only to support takataapui, takataapui tane/wahine, takataapui tane ki wahine, wahine ki tane, whanau, also working with rangatahi and wahine that are working the streets, prostituting in South Auckland, by providing a advocate, support, health awareness, HIV awareness, various programmes, kapa haka, sports. Dealing day to day with issues around benefits, making referrals, housing, also trying to incorporate tikanga within our service. When it comes to areas like gender, and there's a transitioning into adult, and how one tries to identify themselves, we try and use a process of a Maori view in terms of wairua, hinengaro, and the tinana, but also working with family and empowering them. It's a choice they make. It's not something we impose on them but this is how we work. Nga Whakatauki Trust, I knew they had a Maori nurse based in their organisation, and she went out and met with the prostitutes and the transsexuals and any person who had a sexual health problem.

There are also a range of ways that providers have developed their work. Most educators commented on the lack of time they were given with groups. To get around the lack of time, one provider had set up support groups.

We seek to develop young people in various ways mainly through our support groups, So, I mean with the kura, we go up there and we give the information in maybe a seven to ten week block. But, that's in and out you see? But, with support groups it's an ongoing thing, and we're able to do a lot more work with them. And, support groups consist of young people from all walks of life. They come from all over. At the same time we're developing skills around communication and confidence, and grooming and that kind of stuff.

Maori providers are providing for both Maori and non-Maori groups. Some argued that they were better at delivery.

Our service is to a mixture of young people but in terms of support groups predominantly, there are Maori in our support groups. I would say that Maori contribute to about 80-85% of our support groups. So, mostly Maori.

Maori providers work with others in communities. They realise that the issues of sexual and reproductive health are not separate from a whole range of issues, mental health, drugs and alcohol and health generally. The importance of working in with other health initiatives, it saves them money and time, but it also gives others the information.

There's lots of other things like promotional initiatives where we'll work with other key stakeholders within the mental health sector or, within the youth sector, within the sexual and reproductive health sector. So, we'll go and work with those seven agencies, and maybe run an event. We'll see how we can better complement each other. With mental health awareness week coming up in October, we work with the mental health agencies, providers, around what we'd like to do in that week. We're out there to provide the youth component of whatever's going to go on for that week.

We work in with CAYAD Community Action towards Young people And Drugs as well. Others might have a different focus, a community sort of family.., not that we don't but, we will work more around the young people whereas, other providers work more with families and stuff. Doesn't mean to say that we're not going to go that way but, at the moment that's where we're focused. Is drug use just a way of coping with what is really happening, and then we'd like to think that we're working with what is really happening.

Programmes

When running a programme it was clear that as an educator, there may be a set programme but how schools allocated time was unpredictable so programmes have to be very flexible.

Our programme is made up of about eight sessions. An introductory session, and then we're going into each of the six key themes. And, then our final wrap up. Revision, wrap up and evaluation. How the programme gets fitted into the venues that are worked with can be quite different. Like one went for two days. One for about three hours and the other one for about three or four hours. So, those sessions were put together within that timeframe. Others maybe an hour and a half for each session, once a week. Another one may be fifty minutes per session. So, what happens is the activities or the discussions have to be drawn out or compressed to accommodate the time.

The whole idea about the Te Puawai Tapu programme, the six concepts of sexuality, was like it laid the foundation of what sexuality incorporated. Within, each concept area there were lots and lots of topics. Any one of those topics could become a session or, a programme in itself really. And, our programme, even though it has that structure can be guided by what the questions of the participants come up with.
It's based on what you're funded for which is, this is the education programme. And also, limited I suppose by the schools themselves, by how much time you've got.

There are lots of constraints - by the schools, by the personnel that we have within the organisation, how much expertise they bring with them around the topic, and whether or not it is properly informed but, you know a broad view of sexuality not a constricted.., and again it falls back into those traditional romantic, traditional colonised, yeah.

Also mentioned was the lack of research to support Maori educators.

There isn't the body of knowledge yet gathered that actually helps to inform us that offers ideas and insights into Maori sexual and reproductive health, that, says we have considered the issues and this is our body of knowledge and where we come from. Like I was saying. It isn't there.

Maori Health Providers

The need for more Maori sexual and reproductive health providers

Maybe we need more Maori Health Providers definitely. But, what is out there is very passionate and very Maori focused. But we do need a lot more providers out there.

Differences are identified between pakeha and Maori provision of services:

The people that I have come across even, like we have Mana Wahine meetings here, and those managers that come from the Maori Health Providers or the kaimahi that come from there, they're just passionate man. They're really passionate about what they do. You know, getting Maori women in for their screening, cervical and breast screening. And, it's their passion, it's their heart, it's in their heart. You know, I don't see any European outfit as passionate about stuff as what Maori are for Maori. You know? It is about whanau, hapu, iwi.

There are differences in training.

You know, we start with karakia. You know, we say a prayer to get us through the day, to say thank you Lord for all of us being here and healthy and happy, and you know, we bless the kai each time. It's just awesome, you know? But, then I go back to another programme and.., well actually, that's another thing too. That first one, they didn't even provide kai. It was $500 for the training, for three days, and there was no kai. That's really unusual. And, she's like, 'Oh, there's takeaway bars over there, and there and there. Or, you can go down the road.' And, I was like, 'No, kai that's really unusual.' Could you ever imagine going to a hui, no kai?!

So, big difference. And, then the next one I went to was another European based one. They had kai. That was good. They had kai but, they don't do the prayer, they don't bless the day, they don't bless the people. It's business as usual, you know? There's no introductions. No, I tell a lie, the second one they did introduce. It's just a whole different world. Like it really is. And, I know where I'd much rather be.

Adolescent Sexual Health Nurses

There are a range of places that Maori sexual and reproductive health workers are found. Some nurses are employed by Maori hauora services. Nurses can also be under iwi health organisations or employed by Public health. The nurses not only handle clinical care but also the issues of education.

A Maori adolescent sexual health nurse in Public Health employed by a District Health Board.

I am employed by the District Health Board and I work in the Public Health Centre, and I'm an Adolescent Sexual Health Nurse. I work in secondary schools, intermediate, kura and yeah, primary. Well

Child/Adolescent/Sexual Health. And, in terms of the sexual health it's a community role I have. I work with the venereologist that we have here and I'm the Sexual Health Nurse and so, we have two evening clinics a week in terms of addressing issues in the community around sexual health. And, they're free clinics and they're held Mondays and Thursdays. In terms of my adolescent health role, I work with secondary schools and I run health clinics. They are clinics where teachers can refer students to me or, students can come themselves and we look at the health issues identified by the student when they visit me.

Some of the nurses are working in mainstream and some outside mainstream

I've always worked in mainstream, that's one of the things I should have mentioned at the beginning is, it is a mainstream organisation. So, through my linkages and my networking I have a lot of contacts in terms of what's out there.

What the clinics deal with:

The majority of the issues are sexual health in terms of contraceptive health, reproductive health and STIs, Sexually Transmitted Infections. I'm able to provide students who come for contraceptive health with contraception supported by a GP service that works along side us. And, I'm also, through the Sexual Health Clinic, I'm able to make referrals to see the venereologist and it's just a matter of students making themselves available to attend the clinics.

Adolescent nurses are restricted to what age range they can deal with.

In terms of the community sexual health the age range is from fourteen upwards. Male and female. If I'm talking about adolescent health, I'm talking under twenty-five. Fourteen to twenty-four. So, there's that restriction.

The numbers of Maori nurses working in the area is very small:

Yeah, the other point I should probably make is that in terms of myself, I'm obviously Maori and for the last six months they've employed another Maori registered nurse. But, I was the only one in the rohe, in this mainstream organisation. There are registered nurses that sit in there with the Iwi providers but, I don't know how their skill base is in terms of sexual health.

Access to sexual health clinics can be fraught for rangatahi. Rural rangatahi need transport and also the time of the clinic can clash with school hours.

Where we have issues is, students who catch buses who live in rural areas and travel in each day. The timing of our clinic, our Sexual Health Clinic in the community, doesn't equate to the school time. So, there are other providers in the community in terms of sexual health and so, it's a matter of supporting students with the school to let them be able to access time out of school so they can access treatment.

Maori organisation nurses have to be able to multi-task.

So, in my role here as Sexual Health Nurse, I not only do sexual health training but, I'm involved in all of the asthma, COPD, any training that comes into the marae I'm involved in. Because, I need to have my nursing skills kept up. So, that if I do get somebody come in with asthma I know what the latest stuff is about. So, that's the three clinics, and we just started another clinic which, I've been helping to set up. That's run by one of the girls that works at the marae. So, there's a whare there and a shed. She gets the kids in, gets talking to them, 'Do you want help? Do you want to talk to the nurse? Make an appointment before you go.'

There was some criticism of young sexual health nurses who may not have enough life experience:

Like, because you'll find too, that a lot of the nurses that are doing these programmes are actually younger nurses with the newer training you know. Now, we have to go in and ask may I lift the blankets? I'm just going to pop this in, cover you up, are you ok? Is there anything else I can get you? Nursing has just changed so much. It really has changed so much. And, the nurses today are coming out of the schools they've got no idea about cultural safety around elderly, around Maori, Pacific Island whatever, they're very rough and growly. And, old people don't need that. They need loving, they need caring. It's about whanau you know? If they've got no whanau around it's ok to give them a cuddle. I think. You have to be a bit more careful with the opposite sex but.., if that was my mum and she had no family, I would like somebody to give her a hug every day.

Sexual and reproductive health can overlap into mental health as the health workers note.

> *I mean in schools we have health promoting framework, health promoting schools and mentally healthy schools. So, they go hand in hand but, the other thing too is in terms of sexual health, it can be identified as an issue that impacts on your mental health and wellbeing.*

Sexually Transmitted Infections

In the clinics the issues dealt with are STI's contraception and pregnancy.

> *We deal with lots of chlamydia. For the STIs chlamydia is tops, it's right up there. We don't see much of anything else. I've only been there four months remember but, I don't see much of anything else. Contraception. Abortion. Though I've only seen one girl come in for an abortion. Another girl did come in with her boyfriend and an aunty, and the nurse said, 'What do you want to do?' And, she said, 'I want to keep it.' So, she's having her baby. She went to her mum and had a talk to her mum. So, it's yeah. It is really good because, it is about not saying ok, here's your prescription or, ok here's your appointment. It's about getting to these kids on a different level. And, saying you know, you do have other options. So, it's just giving them an informed choice. Definitely an informed choice.*

Sexual Health Clinics are busy on Mondays after the weekend.

> *We want to set up a Sexual Health Clinic here, on campus, so that they can come in. Preferably, on a Monday because, of the ECP you know, emergency contraception. And, maybe a Friday if they know they're going out and they're going to get up to some stuff. They can come in and get some condoms which, they can go and get any time anyway. But, usually they would see the nurse and have an assessment and just find out where they're at.*

Those that come in for treatment will often not return for their follow up appointments.

> *Dealing with the STIs, and then if you have to make a referral, ok? But, the other thing too, in terms of STIs, part of my role is actually to follow up. But, the individual actually has that responsibility. Like give them the dates and the time of the clinic and, you know, and to come back and visit in a week or three weeks later but, they don't turn up.*

There is a high incidence of sexually transmitted infections among Maori. The rates of chlamydia and gonorrhoea are increasing for Maori. Consequences can be sterility for women and men.

> *And, I guess some of the social issues that are out there for us, I mean, there is a high rate in STIs particularly, chlamydia and gonorrhoea in the South Auckland area. And also teen pregnancy is a big thing as well.*

All the nurses commented on the increases in chlamydia:

> *Chlamydia, yeah. I mean I see a lot of chlamydia. We do a test for it specifically. But, yeah there's been a lot more. I guess there has been a huge increase actually.*
>
> *Through pregnancy we do chlamydia and another type of swab. There is a service here on Mondays, that a Family Planning doctor comes in and it's a free service available that anyone can drop in and be seen by them. So, yeah, there is a service available here that we can link in with as well.*

The following are the range of sexually transmitted infections:

Bacterial Vaginosis	*Balanitis*
Chlamydia	*Genital Herpes*
Genital Warts	*Gonorrhoea*
HIV & Aids	*Molluscum*
Non-Specific Urethritis	*Pubic Lice*
Scabies	*Syphilis*
Thrush	*Trichomonas*
Vulvitis	

The other thing I see is that there's a very high STI rate. Like I had a clinic the other day with twelve young mums and ten of them had chlamydia, and three of them had trychomonas and gonorrhea. A very high rate of STIs.

There are gender differences when it comes to seeking help and medical attention:

I can treat the young mums but, I can't treat the men. So, there's a huge amount of education needed in that area. Its a consequence of the sexual behaviour that is displayed in our society today on the whole. There is the sexual health clinic and you know, referrals through.., that we make. And, often give a letter to the males to say you know, their partners have got this and can you please be treated. So, they need to go to their GPs. But, I think often it's in pregnancy that we pick it up because, we you know, we are careful because of the impact on the babies as well.

Nurses also get caught into just treating the person and there can be little time for the important educational work that needs to be done to keep the person safe in the future. Sexual health education is no good if you don't deal with the issues of self-esteem.

There isn't always a lot of time to do the sort of one on one education in terms of personal safety. Like, yes give the condoms but, it's not just giving them the gear it's also about being able to talk to them for the self-esteem stuff. Yeah. So that they can think you know before they act.

Sex education is very often connected to drug and alcohol issues

Because we're working like under sexual health, you know we look at the issues that may impact in terms of adolescent or rangatahi sexual health and that's you know, drug and alcohol issues.

Also clients can present with other problems such as alcohol and drugs.

If they come to you for a sexual health issue and alcohol and drugs are involved you know, it's about having time to work with that as well because it's part of why they're here seeing you. We don't have here in this area a drug and alcohol counsellor but like our service they've got to want to trust them before they can open up. I would like to think that if I make a referral to another service like Drug and Alcohol and other drugs then, it would be good to have the feedback just a brief comment about, 'Oh, yes saw this referral that you gave me, this is what's happening.' You know? But, that doesn't happen. That doesn't happen. Like services are so scarce. There's gate keeping but, there also aren't enough of them supporting young people. But the paper work, the paper work is just phenomenal. I mean we all have it, we all have it.

For sexually transmitted infections, adolescent nurses are required to follow up on the sexual contacts made by a person who has an STI but this is an area they find difficult because of the impact of drugs and alcohol.

For me as a sexual health nurse it's seeing the individual, identifying the problem, screening, treating but then, I have to.., part of my role is to follow up with the contacts so that they get treated. But, because we see a lot of young people who go to parties.., alcohol and drugs has a huge part to play. A lot of the times they don't know who they've been with or, if they do it's just a first name and.., yeah. That's it. So, the contact tracing aspect of my role is very difficult. It's very difficult at times. And, yeah.., yeah, it's part of the role.

Nurses do education in clinics but only have limited time.

I do the one on one teaching in terms of my clinics but not in the classroom.

Educators And Clinicians

One of the issues raised was the gaps between clinicians and educators in the sexual health service.

I moved to Sexual Health and I was manager of the Sexual Health Service which, was a two storey house on the brinks of the hospital, on the margins of the hospital. The doctors were on the downstairs floor and the health educators were on the top story, and there was a sort of staircase between which symbolised the gap between the clinicians and the educators. Some of the clinicians saw me as absolutely ignorant, ill informed, what would I know about anything to do with venereology? I didn't even have a Biology Degree for heaven's sake, it was just an Education Degree, what would I know. So the head of the Sexual Health Service, the clinical side just used to treat me like nothing.

In the past sexual and reproductive health was a predominantly male domain. There was a gendered hierarchy to the way that STDs were focused on and women began to question that focus. Workers in the 1990s began to question the lack of focus on chlamydia.

> *When I moved into Sexual Health we were talking about chlamydia at that time as being the un-talked about crisis whereas herpes and gonorrhoea were very spectacular and the ESR would record it vigilantly, how many cases of gonorrhoea had been recorded this month, and it was sort of almost you know like competing with other Sexual Health Services to see who had more cases and weren't they doing well. It was that sort of warped mentality about it. Whereas, chlamydia which, I was learning more about we saw as being much more about education and also we saw that for young Maori women, that there was lots of undiagnosed chlamydia which would lead to infertility which, would lead to a Maori sexual and reproductive health crisis.*

It was noted that there was rhetoric and sexual stereotyping of Maori within the old sexual and reproductive health service.

> *So, the rhetoric that was coming to us was you know, the issue of sexual and reproductive health for Maori is over-fertility, bred like rabbits, teenage pregnancies was the big crisis, and we started saying no, that's not it. It's actually infertility is the issue, that's the crisis that the population will be dealing with. And, it's about sexual practice and lifestyle which is where the chlamydia comes in. And, unless you're teaching young men and women to take responsibility for their sexual activity, then you're going to end up with this infertility crisis.*

Maori male groups are being identified as being of key interest.

> *And I think there's been a new trend identified that Maori male, middle-aged, and that means below 50 I'm told. They are actually becoming a high risk target group. One, because a lot of men have already had their relationships with their wives, partners, had their children, and now they're actually finding that it doesn't meet their need anymore. And they're looking for same-gender relationships. And it's having to work with families through that. And I think that's really important because we deal with rangatahi and facilitate that information but for our Maori male, and our Maori women, well they always ask most of the time, but it's our Maori male. Maori male don't have that support within their own gender. And also within their own whanau. And they wouldn't ask about it. And usually if our Maori men have come out, it's because they're confident that they're ok. But if a lot aren't coming out, that it means there are a lot of issues.*

Rangatahi - Education

The 2003 Census shows that Maori children 0-16 comprise 24% of the population. While the emphasis of sexual and reproductive health remains on youth, a number of people talked to us about the fact that sexual and reproductive health is a lifelong issue. Peer education has been heavily favoured. Often youth employed in the area can be used to provide 'youth' perspectives to other health areas and this can mean an overburdening of youth.

The term rangatahi is commonly being used for youth. Rangatahi is a common term that derives from 'ka hao te rangatahi' – the new net goes fishing. The term comes from a whakataukii which talks about the need to replace old worn out nets with new ones when you go fishing. Rangatahi in this sense means the younger generation who will take the load for the people. It denotes responsibilities and a sense of working for the people. Youth is a different term. Rangatahi has a sense of being firmly grounded in service to others and connected to whanau as well as strength and newness. Youth can be an individualised focus or peer group focus but rangatahi in the original meaning can't be separated.

Youth is an important focus. But when Maori educators are available and delivering in the few schools that they cover nationally, they have little time with different groups. Educators are clear that sex education is more than about quick fire messages, trust has to be developed, it is important to make the links with the students, to discuss relationships and how to deal with relationships. Rangatahi exist inside whanau and the relationship to whanau is of key importance. Working with whanau is another key limitation.

Peer Sexual Support Team (PSST)– initiatives aimed at rangatahi delivering sexual and reproductive messages

> *I learnt about sexual and reproductive health at school at the age of thirteen. In the schools in those days which were to say 1992 to 1994 they had a group called PSST, Peer Sexual Support Team which, were an organisation based in Whangarei who went to kura. They went around to the schools in Taitokerau area, and I think in Auckland as well but, at the time Taitokerau and they would choose four representatives from their*

school to go on this PSST course. And, at least two girls and two boys, and when I had turned thirteen I was chosen as one of those students. And actually what had happened was when you went to the course you learnt everything about sexual health. You learnt about contraception, you learnt about friends, relationships. You learnt about STIs, at that time STDs, HIV, you learnt about everything around sexual health and reproductive health, the human development, the human body parts, and all that kind of stuff. And, what happened was that you went back after that week in course, you went back into the schools and, if your friends in the school wanted to know anything about sexual health then you would help them out. If they needed condoms, at the time there was no lubrication so, if they wanted condoms they would come to you. And, there would be a pile of condoms in the teachers office, one certain teacher that supported the kaupapa at the time, and he would leave them at the bottom of his drawer for us to distribute out to the students. The four students were chosen on their friendliness with everyone. They could communicate, they could be friends with anyone regardless. They didn't have any problems with anyone else. They also could speak and they could talk to anyone. They could talk to adults, they could talk to their peers and.., yeah, so that was around the first time I'd heard about sexual and reproductive health.

Youth Resources have been developed which some providers did use such as the PHAT pack:

The PHAT Pack. Yeah, it's a resource that's been around since about 2000. And, it's a resource that promotes safe sexual health practices. It did in the initial stages, like we had things like a condom, and a SMINT lolly, and all that kind of stuff. It's a bit of a pack that was small enough for young people to put in their pocket. Now, we've gone to a lot more messages are put in there, about drugs stuff bordering on sexual health. The message got out there, we supported that. It was an idea around developing young people to be ambassadors of this resource to carry on through. And so, that's why the continuance is the way it is now, yeah.

There were varying opinions about what rangatahi know. Some interviewees said that rangatahi knew a lot but others said that they knew very little.

All I can say is that I think that the rangatahi now, the ones in school, in urban schools, are very aware. They do know about sex, they do know about condoms. There's been a lot of advertising about condoms, and I can say at least 90% of those students knew about condoms, knew how to put it on which, was really awesome.

So, I'd say they are aware of the knowledge. I think it's more so reinforcing that knowledge from our point of view going in the schools delivering the programme, it's reinforcing the knowledge that they have got now which, is about the condoms about a lot of sex things, right down to the blow jobs and the oral sex and all that kind of stuff. They know about that stuff as well, and what's hot and what's not. They know heaps about that. I think it's just promoting more and more about the contraception, about STIs, and about the relationships, sexual and reproductive responsibilities that they have with either their partners or the respect that they have for their partners. A lot of them have got the gift of the gab. But, whether or not they're being tika with you? Yeah, there's the other story.

Sexual and reproductive education is mainly aimed at puberty age.

Yeah, and they're at that time, that time of puberty. That's the time that their hormones go wild and they start.., 'Oh, why am I having wet dreams?' Or, 'Why am I feeling horny all day?' and stuff like that. So, it's good at that time.

It was felt by some that the focus on youth is because of social control.

I think there's a feeling that when people get older that they're beyond help so, it's being able to have some measure of control over a malleable population, i.e. youth. And, whether or not that actually happens, I don't know because, you know, messages that came through when I was young were.., were not the ones that I picked up.., um.., or necessarily picked up from.., like a service provider or, anything like that.

The point was made that there is a new generation of really hurting young mums.

I think we've got a new generation of really hurting young mums. Like I think that's one thing that I really have noticed, is that we've got a lot of young people in today's society in itself who I guess with the gang attitude and that stuff in the media at the moment but, they're lost. They really don't know where they're going and what they want to do, and how they want to be. It's only when they get pregnant that someone starts caring for them. Or they're starting to realise that actually you know, there's a real sense of a lost generation. I think it's one thing that I've really.., that's hit me you know, is that we've got a real generation of quite sad.., girls who

actually don't know where they fit or quite where. And, I guess they're teenagers so, they're still trying to find out themselves.

Yeah, identity. But, also just like the whole cultural.., you know, like the Maori, and where they fit, you know? Like the whole.., in the school system and all that. You know, there's a lot of new things being introduced and stuff, and where do they fit and how does it.., They're kind of in between the older generation where.., you know you just go with the flow, and the next generation where they kind of have some opinions, and now there's their generation and they don't know quite where they.., yeah so.

The lost generation needs support especially from whanau. Wider whanau need to look at rangatahi and find out how they are doing.

Yeah, and I think they all need that real support there. Just someone that actually takes.., gets alongside them and sees where they're at and what can be.., what can the system.., Well, someone who's.., I mean family would be the best. I think the best.., the ones that sort have worked the best are the ones that can see that transition into motherhood or, into that.., other ones whose families get around them and support them and stuff like that. But, a lot of families are struggling as well, they don't have the capacity to actually get alongside them. So, I tend to find that I do referrals for the family. I use the pregnancy as something to get a lot of the other part of the family..,

Because they're still quite young they're still having support from the parents or, from the mother or.., yeah. So, yeah, because if you're under fifteen there's not a lot of benefit available and things like that. So, they can't be an independent even if they want to be. So, there's a real gap in that.

It was argued that there is less support today for rangatahi through the lack of intergenerational knowledge but an increase in peer support.

I think it's probably less, and it goes back to my comment before. If they've been raised by elderly grandparents or old grandparents.., then.., they.., they won't have the information. And, they don't know how to go about finding out the information either. So.., yeah.., from that perspective I think it is less. But, it is.., I'm going to contradict myself now but, it is more in terms of the awhi that they receive amongst their peer group. You know, so.., yeah, yeah.

Peer health support.

So, for us in this area, we run the Peer Health Programme in eight secondary schools. And, so the idea of that is that we provide information and education to identified students who then, support their fellow students in the school. And, that's within the school environment. That's all the students basically get identified in the school to be peer support, and so these students can go to them and they can then make recommendations such as 'Have you spoken to the health nurse? Go and see the health nurse.' Or, school counsellor like so.., depending what the issue is.

Some educators are saying there is a lot of basic information that fourteen and fifteen year olds don't have. Even though there is clear evidence of Maori becoming parents under 16 there is little direct information from home or school.

Like the partying on a Friday night, and the Saturday nights and then coming to school and having to go you know, and see the adolescent nurses on a Monday. But, the thing is like with a lot of our rangatahi Maori because, they don't engage with the sexual health component at school they're actually quite ignorant. Unless they're told by their parents about sexual health they don't know. You know, I'm getting fourteen and fifteen year olds asking questions.., you know, can I get pregnant by being kissed? Not knowing that you know, as soon as they get their first period they become fertile. You know? These are our Maori kids you know?

Yeah, yeah because it's not reinforced in home.

And, then to find that you know, you get one or two young boys that are fathers at fourteen. Fourteen and fifteen. You know thinking 'Oh, it's great.'

Self-respect was commented on as being part of healthy relationships

Sex can be about self – denigrating behaviour e.g trading favours or winning friends or pleasing others or allowing your body to be used, doing what you think everyone else is doing. We talk quite a bit about the tinana and why we respect our bodies, you know in te ao marama.

There are different ways of reaching youth e.g running sexual health clinics in communities, at marae and targeting polytechs and other centres of learning.

We've been to polytechs, places for the naughty kids that have been kicked out of school, you know? And, they're a tough group. Tough audience. I work with other sexual health workers and with other nurses to find out about the role of the Sexual Health Nurse.

With rangatahi the point was made that it was important to go to places where they meet.

We go to the marae to the Hauora centre, and to the youth training centre. I don't know how many pupils come there. But, these kids are like older kids and they've gone back to school and they're learning information technology, kapa haka, Maori language and lots of other things that they do over there. So, we want to attract that group. Like we're out in the community helping other rangatahi, and we've got our own here right under our nose that we need to be helping as well.

We want a clinic at the polytech there's thousands, hundreds of students there. So, that would be quite good to have a clinic that is specifically sexual health but we've kind of advertised that it's general. They can come in for anything. If they've got a rash or asthma or whatever.

Some providers are using the HEADSS Assessment.

There's a new assessment out called a HEADSS Assessment. It's Home. Education. Activities. Drugs and Alcohol. Sexual Activity and Social. So, if we can get these kids into the situation where they're with the nurse, and if you're doing an assessment on their sexual health and something else clicks and you think that's not right, you can just go on to do a HEADSS. And, say, 'Look I'd like to do this thing. Is that ok with you?' And from that we find out what might be going on that's tough for them that they need some help with. So, it's trying to catch what's going on all the time.

The Headss Assessment

(Adapted from Goldenring and Cohen, 1988)
The HEADSS mnemonic forms the basis for an assessment that provides a 'psychosocial biopsy', an opportunity to facilitate rapport, risk assessment and a guide to any interventions which may be necessary.

H – Home Environment
· Where do you live?
· Who lives with you?
· How does each member get along?
· Who could you go to if you needed help with a problem?
· Parent(s) jobs? Recent moves? Run away? New people at home?

E – Education/Employment
· What do you like/not like about school/work?
· What can you do well/what areas would you like to improve on?
· How do you get along with teachers/other students?
· Grades, suspensions? Changes?
· Many young people experience bullying at school – have you ever had to put up with this?

E – Eating/Exercise · Sometimes when people are stressed they can over eat/under eat. Have you ever experienced either of these?
· In general, what is your diet like?
· In screening more specifically for eating disorders, you may ask about body image, the use of laxatives, diuretics, vomiting or excessive exercise and rigid

dietary restrictions to control weight.

A – Activities and Peer Relationships
· With peers? (What do you do for fun? Where? When?)
· With family?
· Sports – regular exercise?
· Hobbies? Tell me about the parties you go to.
· How much TV would you watch a night? Favourite music?
· Crimes? Arrests?

D – Drugs/Cigarettes/Alcohol
· Many people at your age are starting to experiment with cigarettes/alcohol. Have any of your friends tried these or maybe other drugs like marijuana, IV drugs, etc. How about you, have you tried any? Then ask about the effects of drug taking/smoking or alcohol on them, and any regrets. How much are they taking, how often and has frequency increased recently?

S – Sexuality
· Some people are getting involved in sexual relationships. Have you had a sexual experience with a guy or girl or both?
· Degree and types of sexual experience
· Number of partners
· Masturbation
· Contraception?
· Knowledge about STDs
· Has anyone ever touched you in a way that's made you feel uncomfortable or forced you into a sexual relationship? (History of sexual or physical abuse?)
· How do you feel about relationships in general/about your own sexuality?

S – Suicide/Depression/Mood Screen
· How do you feel in yourself at the moment on a scale of 1-10?
· What sort of things do you do if you are feeling sad/angry/hurt?
· Is there anyone you can talk to?
· Do you feel this way often?
· Some people who feel really down often feel like hurting themselves or even killing themselves. Have you ever felt this way?
· Have you ever tried to hurt yourself or take your own life? What have you tried? What prevented you from doing so? Do you feel the same way now?
· Have you a plan... etc.
S – Safety · Sun protection, immunisation, bullying, carrying weapons
S – Spirituality · Beliefs, religion, music, what helps them relax, etc.
(Adapted from Goldenring and Cohen, 1998, 'Getting into Adolescent's Heads', Contemporary Paediatrics, pp75-90 – In Access SERU, Improving Young People's Access to Health Care Through General Practice, 1999)

When asked about rangatahi and their knowledge of sexual and reproductive health:

> *I find it really refreshing as to how responsible the kids are today. One thing that I've noticed is that we have males in their early twenties coming in and saying 'I've just got out of prison. I've just met this really nice girl, I have had chlamydia before, and I want to get checked because I want to make sure I'm ok before I start a relationship with this girl because, I really like her.' Another young gentleman came in because he was having erection problems, and was saying, 'I want to please my woman and it's you know, all about me and there's not a lot in it for her.' So, you know what I mean? So, being really considerate. Couples coming in together to get the pill. You know, saying, 'We've started a sexual relationship six months ago. We've been using condoms. We're ok with each other. We know where we're at. This is us. We want to stop using condoms and look at the*

contraceptive pill.' So, there are responsible kids out there. And, then you get the occasional one that comes in, 'Oh, you know I've just been rooting around, and I don't really care, and I've probably got this and that.' And, you know, 'Just look at my fanny.' You know, they don't care? But, not very often, honestly not very often.

Like coming.., even the ones that are getting pregnant. You might find that they have slipped up once or twice but, you know their practices are really quite good. I'm seeing. That there practices are quite good, and that's Maori and European alike.

What do I think about that? I think.., the efforts often go into those populations that.., that it can be considered easiest to control, easiest to influence.., I think youth do get a lot of input because they are seen as you know, our future and all that kind of thing.

But, it also feeds into this societal thing that youth is sexy and anything older is not. And.., I don't agree with that, and in some ways it invisible-ises our sexuality and sexual and reproductive health in older populations. I think it also feeds into the thing that sex is everywhere but, it's nowhere.

It was pointed out that although organisations wanted to extend to adult services, the funding was unavailable.

The original intention of our organisation was to have a service whereby adults worked with adults, and youth worked with youth. So, still following the peer education model but, it was the funders who in the end who wanted the youth.

Organisations such as the AIDs Foundation do focus beyond youth and deal with older men.

Rangatahi Communication

It's a real skill to interact with rangatahi well.

Yeah, and that's where we've got an advantage. Like, not only the stuff that we teach here but, also our own backgrounds. Because, you know, when we talk to the kids we've all noticed that they can approach us with anything. And, we make sure that that's said throughout our sessions you know, throughout the eight sessions. And, throughout the week they just keep coming up to us with questions, and they want to know a lot. And, you know, that's pretty good that they can come up to us and do that.

Communication skills are required that are unique in the sexual and reproductive health area

The minute we go in we try to be as up with them as possible. We can make it in their face so, they really don't have a choice to feel withdrawn and closed so get rid of all the isolation from anyone, get rid of all the fear. Like when we go in we set guidelines. But, we ask them to set the goals so, they're in control of the class not us. So, that they feel that they have some kind of authority or, some kind of control. Whereas, with other classes you know, they're just looked down on pretty much, aye? They feel they have you know, some kind of power. We don't dictate to them.

You know, we don't stand up there and point the finger you know, you should do this, do that and just bombard them with information. We sort of give it to them in a way that they can understand it and, visual things, audio.., we do play a lot of music and all that stuff.

What we do is we promote those messages like safety, safe sex, in our dramas. And, we implement you know, kapa haka, we implement dance, we implement things that.., rangatahi can identify with but in a kaupapa Maori perspective. I mean, I know that these originate from 'other' you know like break dancing. So that our programme's kaupapa Maori. Deliberate. Yeah, usually the drama would be our first point of contact with the school. And, they're really, really, really, really, like nervous and stuff like that. So, when we get in there they're like, 'Oh, yeah, we've seen you before.'

Language is a key issue with youth, using language that connects with the audience.

We have to kind of come to their level whatever it is. We just had a special needs group. And, they were really, really chatty. They were full on. They didn't want to know about the big words but, I mean, if you've got a fallopian tube you know? If you're talking about the fallopian tube or the ovary or, the fimbriae, there's no other

word for them, you know what I mean? So, we have to simplify it as much as we can. So, tubes, ovary, fimbriae we just go, finger like things, projections or whatever. I mean you know, for a vagina or a penis you can name them something else, a dick or whatever. And, they can relate to that but, some of these other… because, we're teaching anatomy and physiology first, and some of these things you just.., like epididymis, there's no other word for epididymis. You cannot.., there's just nothing. It's just a tube that goes from the penis up there and you know, around and.., So, we have to put it into a lot simpler terms . The first group, the special needs group, they were very, very interactive and really interested in the stuff and wanting to know what it was about. This other group that we're working with, they're you know, naughty kids that have been kicked out of school basically. You know, they're disruptive in class, they don't listen, they talk amongst themselves, they swear a lot. They use 'f' words and 'c' words, and.., so, it's a completely different learning environment. There are two girls in the classroom that are very interested but, the boys just disrupt the class so much that the girls are going, 'Ssshhh.' All the time, you know? 'We want to hear this stuff. Can you just sshhh.' You know? But, it just doesn't work. So, we have to talk over them all the time.., and the girls are trying to listen and.., But, you know, and talking with them you're talking about dicks and fannies. You don't mention vaginas and penises. There's no.., you know it's their kind of language that you have to deliver it to them.

The knowledge base of rangatahi is varied. So education has to cater to a number of learning levels.

A big issue that I unmasked was because, when we go into schools the first thing we do is give them a peer/pre test on what you know, just to see what they know about sexual health. And, one thing that came up well, at one College alone for me, was that no one knows anything about contraception. They don't know what the word contraception means. Like if you were to say condoms, yip. They know about condoms but, they wouldn't class it as contraception because, they don't even know what contraception is. So, yeah. It's literacy. Yeah.

Starting point is sexuality, and sex.

Our first module is sexuality, sex and sexuality. So, that being the first is actually quite good. Because, that's saying to them.., you know, helping them to be aware ok there's different types of sexuality. There's heterosexual, there's also gay, takataapui. Oh, then they know so, just being inclusive so that they know when they come back to our classes they're not going to be putting anyone down.

Rangatahi are asking so many questions about everything, everything. And, we build an environment where they can just open up, and due to a lot of influences around them, they know.., they've seen or they know a lot about sex, about sex, about Beyonce's big booty or, texting sex texts as they call it. They know a lot yeah, so it's just channelling that knowledge into a.., a better bubble, if you can say.., a round bubble instead of being a little berry shaped.

Yeah, yeah. There's a lot of that. I would say too that, is that as long as they're talking and they think they know. It's those ones that aren't, who aren't talking who aren't saying anything is the ones that we should be more afraid for and more scared for because, they're the ones who would probably get in a situation where they might have to.., they've been forced to have sex and they won't say anything. Yeah. Whereas those ones, hopefully, that the ones that are talking will say something, yeah. So, that they don't get themselves in predicaments and into situations where they are maybe being abused sexually, physically.

Gangs are a big issue in some regions

Actually, just last week at a meeting we identified that issues that are out there at the moment and a lot of it is gang, gang related.

The importance of providing information that is relevant to contemporary Maori youth was stressed.

So, it's important to provide information to contemporary Maori youth that's relevant for contemporary Maori youth.

For some educators they felt that there was a wide diversity to Maori views and that the urban view was just one of many.

Maori have such diverse views whereas - someone may come from a very traditional background, which may be traditional romantic or it maybe traditional traditional or, it may be traditional colonised. It's kind of hard to wade through some of those things. And, then you'll have the very urban probably very different way of thinking

about things. And, then you'll have others who have worked in isolation, and who have drawn on personal experience to guide them.

Rangatahi Trust And Privacy

A key issue for rangatahi for effective sexual health practise is the building of trust and privacy.

Working up in rural areas we have PHOs now, and PHOs have picked up in rural areas have a sexual health contract for adolescent or youth in their regions. And again, there are issues for them one of which is, the GP delivers the service but, if the GP is the same as the whanau GP.., so kids won't go to there. Especially if we're talking about sexual health, if we're talking about sexual health issues for them. It's a small community so you get people talking so, there is a confidentiality and privacy concerns.

Rangatahi need to be able to trust health professionals. If they don't have trust, they don't seek help which is one of the reasons for the high Maori rate of sti's and teenage pregnancies.

But, even with the adolescent nurses, they find it's all built on trust especially around Maori children. And, if they don't trust the nurse they won't go and see them. So, if they have an STI or you know may be pregnant they fall through the cracks. You know, and that's why we have such a high rate of teenage pregnancies. Yeah, and why our chlamydia rate and our gonorrhoea rates are climbing.

Issues of privacy for rangatahi can be protected by running general clinics, wider nursing issues so that the youth can maintain privacy.

How we've set up is we've said it's a general clinic. We haven't said it's a Sexual Health Clinic although, that's what we're aiming for. Because, they can come in for a rash or asthma or, whatever. Ok? And, they do. You know, they do.

So, if there's six of them sitting in the waiting room they have absolutely no idea what they're there for. That person could have asthma or, they could have an STI. Who knows? We don't want them to be sitting there feeling whakama because they know that.., you know, that that person sitting next them is saying, 'That person has an STI.' Or, 'She's having sex. She's only fourteen and she's having sex.' You know? So, there's no guessing. And, that's done as a general clinic.

Everything comes back to education about relationships because issues such as an age gap can cause different responses.

Its the ability to create relationships that are healthy that is important. If we're looking at a young girl, older man, the young girl will have the knowledge in terms of STIs, contraceptives, blah, blah. The older male won't because, he's obviously come from a different generation. Like, that generation don't know about sexual health, they don't understand their own sexual health. They don't recognise the signs , they don't.., you know. And, so they come from the view point, 'Oh, well I must have got it off her.' But, hello! They don't look at where they've come from or, where they've been. You know, shift the blame to somebody. So, we're also dealing with people or individuals from that aspect. And, so you know, our young rangatahi today, I think, are more informed and more aware, it's just that they haven't had the role modelling from within the community.

Rangatahi - Culture

From my experience and being in the city and working in the city, urban Maori, there is a lot of sexual activity at a young age. Younger ones from the thirteen to seventeen mark and, yeah.., multiple partners.

Rangatahi can be disconnected from knowing who they are.

Like whakapapa. I think it gets a back seat when, it comes to being a young person in the city. And, being a teenager. They can be disconnected from who they are. They might be able to rattle off their iwi but, what does that mean?

It's a culture, youth culture is a culture. It's a mean culture.

I think they'll take something on and maybe the Pakeha western way of working isn't what they're down with. They want to be down with something else lets say the American culture. If you were to ask someone who they

are.., that's me. Which is all good as a way of expression but, to the point where they start to think it is them its problematic.

But a rangatahi forum who are role models, positive Maori, male, female, whatever. But it's actually to work with rangatahi because we've found, and I've read from the previous research notes that a lot of it, rangatahi learn from rangatahi. And this is a really, really good way to get the message out there. And I mean the families, always find beautiful rangatahi appealing.
So the goal is, while it does appeal to rangatahi, it's actually an approach to families, that not all rangatahi are that way, not all rangatahi drink. And not all rangatahi are naughty. So it's not saying that all these rangatahi are still at school. It's saying that some of them maybe on courses. But it's actually about promoting positive role models. And that was one way we thought we could work around Wellington. One of the other things is that we've had a lot of calls from Auckland, South Auckland around the programme. And so it would be nice once we've gone through our stabalising exercises, that we will develop outreaches. And it's not so much for us to go up to Auckland and deliver, but maybe their maybe iwi that we can train to deliver to their own. And it's about, you know, no good Whanganui telling Taranaki what to do because they just wouldn't listen. So therefore we could support others and I think getting the message out is really, really important.

Schools

Because schools are regarded as the primary place for sexual and reproductive health education, schools were discussed a lot. Unfortunately the area of sexual and reproductive health is not taken that seriously by many schools. Those working in the area found huge differences from school to school. There still seems to be the view that sexual and reproductive health is about teaching about sex but the bigger education component is in teaching about relationships and life/social skills.

When it comes to working in schools, the educators are not determining how much time they get with their students, it is the schools. Many times the sexual and reproductive education will be to fill in a time slot. So providers are having to take the time they can get which means their programmes have to be flexible and adaptable. Also there is variable audience receptiveness.

With the special needs group we could have done that over eight weeks because, they just had so many questions. And, they were so interactive. They really, really were. With the learning centre, the first day we went in for an hour and a half and we were out in an hour. Because, they just weren't interested. So, we packed it up and went home basically. Which is kind of sad. The next week we went in we were more prepared. Because, we were actually quite shocked as well. When we walked in there we were like, whoa. But, with the other guys we were given two hours, with these guys we were only given an hour and a half. So two hours wasn't enough, and with these guys an hour and a half is kind of too long because, their attention spans are short as well. It just depends what slots they've got in the classroome e.g from 10 to 12. Their morning tea must be quarter to ten to ten 'o' clock, and then we went from 10 to 12, and then they were off for lunch. If we went over, which sometimes we did because like I say, there just wasn't enough time. The teacher would say, 'Right you guys can come back a bit later. So, have your half hour and just come back a bit later.' Yeah, so it just depends on what slot they've got, what they need to fill in.

In some cases, schools are quite prescriptive about what they want taught.

One school I know, they wanted one session on, funnily enough, contraception and STIs, disease prevention and pregnancy prevention. And, we said, 'Look we know that it's not effective to have those one offs. We want to have more sessions. How it could work is we could do..,' It still didn't really, really work. But, we said, 'Give us three sessions so, we have one session to be able to just kind of ease, just kind of get to know each other, just kind of ease ourselves into the class and the class into us, getting to know us. Then we talk about those other topic areas and..,' It put a much bigger work load on us because, instead of just two educators it was me as well. To be able to cover all the classes. And, so that's probably the extent of the input that they had. Usually, we say this is our programme this is why we like to do it this way. We like to build up the trust and rapport with the students so, that whatever we're talking about will be able to be maximised.

Teaching in the sexual and reproductive health area is specialised and it was argued that teachers either didn't have time, weren't interested or they were interested and sometimes not supported by the school. The providers in some cases have spent many years fine tuning their programmes.

Also, more comprehensive programmes have been shown to be more effective than the one offs. And, it's hard enough as it is because, you're having outside people coming to talk about this subject area.. Sexuality, cannot be dealt with by teachers, they have to bring other people in.

Comment was made that sexual and reproductive health was isolated to separate sessions but that it could be part of other sections of the curriculum.

Yeah, it should be incorporated. Well, right throughout the curriculum. And, it was talked about how sexuality could be incorporated say into English or, into maths. You know? So, that it becomes much more transparent rather than as one off.

Most of the educators we spoke to make their programmes available to other groups e.g parents, teachers and other organisations

I think the programme is available to the parents of the students. It is also available to the teachers and other organisations. I haven't come across that situation because I'm so early in the programme. Yeah. I think it is..,

Time spent on sexual and reproductive health in classrooms is varied.

I think the shortest one is.., not an hour a week for two weeks so, it would be about two hours. Two hours would be the shortest time that we spend with a group, two hours. You don't actually build a relationship with them over those two hours but, I would say that you do pass on knowledge yeah, information.

Comments were made on the importance of evaluation for example in later years at school.

While they're in the 7th Form or just going on to varsity, yeah. That would be good. I think that would be one way to measure whether or not the programme that we deliver does work.., or has made some difference.

It was pointed out that children who are younger and their whanau should be worked with.

I think there does need to be a lot of networking with major groups and you know, really assist teenagers, and kind of identify the at risk children a lot younger. Say ten year old age.., you know, not the teenage thirteen, fourteen, fifteen age.., and sort of you know, get to know the families and work with them.

There were many barriers identified to teaching in schools. Adolescent health nurses are not allowed to educate in schools now even though they have the expertise, it's the teachers that have to teach.

In terms of the sexuality education side of my role it is purely support and resource for the staff, the teaching staff in the schools. As a adolescent nurse we have been told that it's no longer our role to take on the teaching in the classroom that, the teachers actually are the ones that are trained to teach in classes. But, we can still go into the classroom and support the teachers, depending on sexuality education programme that the school have devised. Under the Health and PE curriculum, sexuality education is a compulsory programme. And so, schools actually have to make that commitment.

I support the staff and the students as well. And, I can do that through a number of ways, through my Student Clinic, health clinic or through the classroom teacher or, through the Health Coordinator in the school.

There are barriers to the delivery of sexual and reproductive health programmes in schools

In terms of barriers, and there are barriers because we have 77 schools in this rohe and that's including our rural schools, and not all the teaching staff are comfortable with teaching sexuality education. There are a number of limiting factors. One is, if they're an old teacher they haven't gone through the process of sexual and reproductive health learning, and so that's why they've always relied on me or the Public Health Nurse in their rural areas to support the school or, deliver the programme.

There is a lack of professional development for teachers to teach sexuality education

But, also there hasn't been the professional development for teachers to teach sexuality education. And, if we're talking about kaupapa Maori there definitely isn't a professional development programme that is in this area. That is in this area. We support as best we can but, we're not trained to deliver any Maori focussed education. So that's a gap for us. So, I'm talking about for myself as a registered nurse.

The workload of teachers also has to be taken into account, they already have big workloads and they are being asked to add another thing into their work.

The other areas are if we're talking in terms of rural teachers such as stand alone teachers in their schools, they may have a huge overarching role in terms of being the manager, principal and then teaching.., their work load is so great that programmes like sex education are probably only just given a curtesy look at in terms of

yes, they have the mainstream books but, they don't know how to put the programme together so that the kids get a better understanding of where sexual health for them sits in their growth, in their personal growth.

There is quite a bit of variation in schools themselves over their understandings of health and their attitudes to health as part of the curriculum

The basic programme we have for our urban schools is the Ministry of Health as part of the PE curriculum. And because, again, and I have to think in terms of nurses is that, we as individuals don't have a lot of insight into the curriculum so, that we can better support our teachers. Each school has a different way of understanding health.

Some schools see health holistically and some don't.

Some schools are really good and they have a very holistic view point of health. Whereas, other schools just, I suppose for want of a better word, they just pay lip service. They're happy to see the nurse for head lice, maybe hakihakis or, runny ears but the whole holistic aspect of health they either don't understand it or they choose not to.

Schools vary in what they teach about sexual and reproductive health depending on their attitude to the health curriculum. Some eugenics thinking coming up here around the poor needing to control their breeding.

Well, it depends on the school, and how they view health. Where is it as a priority? Our contracts are to work with the schools.., decile one to four schools. They're the ones that get most of our help, ok? And, that's right across the board in terms of all health issues, around nutrition, immunisation.., yeah, and so again it's where the school.., how the school perceives health and if it's a priority.

Nurses have changed their approach now.

Yes, they'll have the Public Health Nurse come in but, they see us mainly as being somebody that will react to whatever the issue is. Whereas, our role has shifted now in terms of yes, we still do the reactive stuff but, we also have a broader perspective now in terms of we need to be encouraging schools to look holistically.

The theory is that nurses will train the teachers and it was thought in one interview that nurses would need to work with teachers over a two to three year period for them to become equipped to run the programme but because of staff turnover that was nearly impossible.

And, see the role of the public health nurse is to train trainers. So, they train the teachers to actually deliver in the classroom, and what the nurses do is they go into the classroom and support the teachers, the teachers will do the delivery. And, they may do that for a whole year, and then the next year they may step back a bit. You know, because like they're helping them in their role, and then the next year they step back and let the teacher's do all the delivery but, maybe by the third year the teachers are well able to deliver the programmes themselves. It doesn't work though because of the staff changes in schools and it's how well supported that person is by school management like again if they can be strong enough to fulfil that passion. Because if schools aren't sending their staff off to training opportunities then they fall to the wayside more or less.

So teachers or the principle have to take a special interest otherwise things don't happen. And, that's for anything not just sexual health.

It was pointed out that schools were variable in regard to how they see Treaty rights as this inhibits their support of Maori students, their support of te reo Maori and kaupapa Maori.

The other issue in terms of health in general is that schools need to identify where they stand in terms of the Treaty and, how they go about supporting their Maori students. If the school just clumps them all together and gives very little recognition to Maori then in a topic like sexual health or sexuality education where it highlights those things of a Maori programme versus a mainstream programme.., the school will go with the mainstream. The school will go with the mainstream.

It was suggested that iwi providers need to be more proactive about working in schools.

You know, like if our iwi have got the resources they need to be using those resources to go into those schools, alongside the adolescent nurses that sit within the mainstream system, and work with them. You know like a parallel. The adolescent nurses deliver on a mainstream pakeha level, our Maori providers deliver from a kaupapa Maori basis.

It needs to be delivered by both mainstream and Maori, Maori providers, the sexuality programmes. They need to sit hand in hand with the adolescent nurses when they go into the schools to teach. They actually need to bring an iwi provider in or, a Maori who can deliver from a kaupapa Maori basis to our Maori children. So, that they're both getting the information in both English and in Maori. But, in terms of the Maori it comes from a whanau, hapu, iwi perspective yeah. But, sitting alongside the curriculum of the mainstream.

It was recognised that creative ways needed to include whanau. This could be done through schools.

You have in the schools, you have individuals like me, like the adolescent health nurse who can do the one on one with the student. But, also do the resource role with the school, staff, so that they can see where things fit. Ok? Then they get to go home, and the parents are on board. So, that we start to get a more rounded perspective. And, the way of doing that would actually be through the newsletters, you know that the kids take home at night. Bring in some puberty stuff for the parents to look at and talk to their kids about.

Another issue raised is that of teachers coming in from overseas who are not familiar with Maori, te reo Maori or the Treaty.

Yeah, so we have to be really careful about that. We have to be really careful about that. The other concern is that we have a lot of overseas teachers who come into our country, into our region, into our schools, who don't have an insight into our rangatahi or, like the youth culture. They might have a general perspective but, they don't have a real insight. So, they struggle to develop a rapport initially.

There is need for a broader curriculum and more education in schools.

That will be because the policies and practices that have come down in terms of hauora, is that it's reiterated through the decision makers. Maybe the BOTs or the Principals, and then down to the teachers, and they wouldn't think that sexual and reproductive health would only happen when Te Ahurei walks in the door.

Working in schools requires creative thinking to assist teachers who have a heavy workload already

Yes, yes, yes. As I'm flying through with the teachers. And I'm also aware that teachers because, my wife is a teacher, that they have a lot on their plate. So, what other mechanisms can be in there to assist that? To assist the teachers? You know, because they do have a lot of work to do. You know, I would never ever think to try and do.., have them do anything over and above what they already do but, maybe just the mentality and the attitude around hauora.., being emphasised in their approach to the young people. Instead of thinking they have to design something different or some new module or curriculum, curriculum activity just to cater for an extra.., or, an extra yeah, seemingly do at the time now.

Education

But, the education is awesome, you know? Explaining everything, the informed consent, well informed, all that sort of stuff is.., explaining every different angle and double checking with them that they know what we're talking about before they leave.

Comments were made about the need to educate clinical staff about sensitive treatment.

'Well, there's your catheter bag Mr Jones. I'm out of here.' I'm not.., I haven't told you why it's gone in there, and I haven't been culturally sensitive and said I'm going to hold your penis now. You know?
My job is Kaiako Rangatahi which, is the sexual educator and basically my job is to promote sexual health with a Maori view. So, having a Maori view towards sexual health.., and that would cover six concepts, and those concepts are sexual behaviour, relationships, human development, sexual health, society and culture, and contraception.

So, there's the six concepts that we go out to the kura and teach the students, averaging from the ages of thirteen to fifteen, about sexual health. So, that's my new job as an educator is to deliver a programme set up by Te Puawai Tapu, in the beginnings, and I'm there to develop and spread the word basically. Yeah. So, that's my job. In the high percentage Maori schools of the Wellington region. My impression is the position itself is only made for certain types of people. If you are a person who is a hoha person and can't handle tamariki at that age because, they've got a lot to say, and you have to be open, then it's not the job for you.

I've seen a lot in the last three days. I've seen the extremes of haututu tamariki who just want to talk in the corner, and don't want to pay any attention. And, I've seen.., well, to the good side of our rangatahi, the ones who are participating in the conversation, in the discussions, in the debates and.., yeah, so it just depends on the individual who is delivering the programme whether or not it's for them or not. Yeah.., you really have to have a passion for it before you take it on. I've always had a love for sexual health, always had a love, and so I just took it on. I knew it was going to be at times tense you know, a bit stressful and I love the position.

The Importance Of Wairua.

Although somebodies gone and told that person, you're going to die in a week, boom, the wairua's going awwwww, the whole bodies going awwww. So you've gotta turn that around, well that message. Because words can kill. The power of the voice can kill. So you need to get in there and say, hey. Live life to the fullest, be happy. You try and pick that person up to believe because it's also within the tinana, all the chemical and whatever you call it, picks up to go to, and that spirit becomes stronger.

And it can outlive its use-by date because you've just picked them up. You hear many stories about, I've seen it many times, you know, and I've gone to death beds of many kuia and kaumatua, and we're told they won't see the night out. They're still there, 6 months, 7 months, a year later because they were waiting for something, they wouldn't let go, until that something had been done, then boom, they're relaxed, they're finished. But what kind of phenomenal thing would you call that? Where are they teaching that in the curriculum? So it's those kind of things that we have to respect, to know that it exists, and to be able to give it and bring it out and share it and look after it and make an awareness to others about those sort of things.

Training

I knew nothing about STIs. Knew nothing about the diseases you could get. Didn't have a clue, not until I started doing those classes, and teaching the students at the same time.

We get other speakers in you know. Like the Aids Foundation and others might come and do a session on something. So, we break it all up so you don't have the same person you're listening to the whole time. And, it's very Maori focused, you know.

I went to the Te Kotahi training up in Gisborne, that we run, that was a three day course. Absolutely fantastic. You know, they do karakia, they have waiata, they play games and its very Maori focused. It's really good. And, that's how like I run my programme.

I am Maori and that's how I want to run it. My co-worker knows te reo and I'm learning because Maori is compulsory here. So, it's part of the kaupapa. So, she'll do more the Maori component, and I'll run the programme.

Sexual and reproductive health training for nurses, there is some training available through Family Planning and also Independent Practitioner Associations.

I did training through Family Planning Association in Wellington. I did a three day course with them. I did a two day course with WIPA just recently. Wellington Independent Practitioners Association. Yeah, so there's WIPA in Wellington and MIPA up in Manawatu, Palmerston. Around that area it's MIPA, Manawatu Independent Practitioners Association. So, that Independent Practitioners Association is the doctors. So, the doctors and nurses go to WIPA and do their training. So, that's Community Nurses, Public Nurses, Health Nurses that work in the community. Yeah.

There are some resources available for sexual and reproductive health workers but little to nothing that is Maori.

So, I just did a programme with WIPA. I mean lots of readings. The Ministry of Health documents and WIPA have got a Sexual Health Manual out that's as thick as that. That one we've read through. So, there's lots and lots of reading, and basically that's what we did for the first two months, was read. I mean, my eyeballs were just about falling out.

Some providers organise their own training.

So, there probably isn't enough training. I'll be running a programme here. But, I'm trying to get my skills up so I can run this programme as well. But, also I would get a lot of speakers in. We're looking at doing it in November. We have a three day training which covers anatomy and physiology, sexually transmitted infections, contraception, menopause, puberty, the Aids Foundation come and give a talk, natural fertility.., And, I've actually got one coming up on.., we have a three day one once a year. And, then we have two one day ones at separate times of the year. I've got a one day one which is my first, on the 5th of September. And, I have got two guest speakers coming and one is from Level J in Wellington which, is the Abortion Centre, and another lady coming from Natural Fertility. Which, I've really discovered is quite underestimated. Absolutely. I panui out to the nine.., there's nine Maori Health Providers about the training. Yeah, so I'm just in the middle of setting that up at the moment.

Teen Pregnancy

Teen pregnancy is high among Maori and there was a great deal of discussion about it. Many Maori have first hand experience of teen pregnancy either among their own or extended whanau. Often parents, grandparents or wider whanau can support the parents or take over parenting the child.

I've only dealt with two pregnancies recently. And, one was a sixteen year old who decided to keep her baby which, was really, really cool. You know, just said to her you know, "Are you sure? What do you want to do?" She said, "I want to keep it." She said, "Well, go and have a talk to your mum." And she ended up keeping it. And, another nineteen year old who was just adamant she knew what she wanted, she wasn't upset. She's.., the test came up positive. She said, 'Sweet. Can you book me in.' Not a problem. That was her stuff. Are you sure about this? Yes. You know, just putting it out there and she knew exactly what she wanted. She said, 'I'm not in a position to have a child. He doesn't even know. It was a one night stand.' Or whatever it was, I can't remember. So, I'm quite surprised that they do kind of know what they want and.., and I think a lot of it is that they really do know.

Prescribing contraceptives

I think if we did a chlamydia check, it's just a urine and a high vaginal swab which, they can do themselves. So, you don't even have to look at them. They can do it themselves. And, Aids would be a blood test. I haven't been trained to do a blood test although, it's not that big a deal but we don't even have a doctor attached to us as yet. So, we will need to because, what will happen is that eventually, if somebody comes to see me and says I want to start on the pill, I'll do an assessment.., have you heard of the WHO Category for starting on contraceptive pill? And, there's four categories and they differ. I can't tell you exactly what they are but, they go through a lot of questions. Are you a smoker? Any this or that in that family? Do you have any of those things? Your age, and so on and so forth, and there's a whole series of questions. And, you would work out whether they're a WHO 1, 2 3, or 4. WHO 1's get the pill every time and 4's just never get the pill. They just don't fall in that category. So, then if a sixteen year old came in and said, 'I want to start the pill.' We do the assessment, then I would actually prescribe the pill to start. So, if I had a doctor connected to me here at Kokiri then, I say, 'Ok, this is where you're at. You come under the WHO 1 Category, we can start you on this pill. And, nine times out of ten L..?.. So, I would start her on the pill. Any problems, do the education for a pill start. Any problems or, any concerns come back and see me. If you're fine you take it for three months. Here's a prescription to get the next six months, and that's all you need to do. That saves them going to a doctor. Paying for a doctor. Asking your mum and dad for the money to pay for the doctor. You know, mum's seen that they've been and paid on the screen or, whatever you know. It confidential, it's free, it's educational yeah, it's all of the things.

Unplanned pregnancies are not viewed as a negative among Maori necessarily. Part of the reason for this is concern to keep the fertility rates among Maori high. This could be a result of the fact that the Maori population was thought to be a dying race in the early 1900s.

And, especially for Maori you know, it's sometimes viewed as a good thing because it's carrying on the hapu. You know, it's making the hapu stronger. It depends on how you look at it. But, for some young women who find themselves pregnant.., they.., are not happy at school. They're not happy at school, the schools not engaging them. This is a different focus all together. If they find themselves pregnant and so, ok, it's a bit of a dilemma initially until they make a decision as to what it is that they're going to do, and if they choose to go with the pregnancy, their focus changes and it also enables them to mature as well. And, so that when they have

their baby things start to click into place and then they can see a future but, their future now includes their baby. And, so they become more motivated. They become more motivated.

There needs to be more support in schools.

But schools have to look at ways of supporting like there's a school I think it's in Wellington where now the kids come in at 10:30. They start school at 10:30 in the morning. They're more focussed, their achievements are higher, they're happy.

Support groups for teen mums are important but rural areas can be lacking in support.

We do have a teenage mothers support group here which, sits with the alternative education. Maori girls do go to that, they're able to take baby along to it. So.., yeah. They're in an environment where they're with other girls of their own age that they can talk to about their baby issues, and still get on and do their work. So, it's actually not a bad place for them, you know? But that group is here in town there's nothing up in our rural areas other than whanau.

Teen pregnancy is not always an outcome of lack of communication with your children:

My own daughter, she's sixteen she's just had a baby you know, and I've spoken to her, when she was growing up you know I talked to her around puberty and I talked to her around teen pregnancy, and it didn't stop her from getting pregnant. You know, that was the sad fact about it.

Teen pregnancies can make rangatahi grow up. There is sometimes exploitation of younger people by older partners.

Because it's really, it's not just the sexual health, the teen pregnancy, the contraception it's also again showing our rangatahi how to develop a relationship, you know? Our wahine are a lot more mature, you know than their tane counterparts even though they sit in the same classroom. It's happening more now where you're seeing a lot of older women who are getting pregnant to younger men, younger boys. Yeah, that's frightening.

Maori girls may can end up in abusive relationships if they don't understand relationships.

Yeah, and yet you talk them about it and they think, 'Well this is the best thing that's happened to me.' Our rangatahi think that it's better having a boyfriend than no boyfriend. But, they can't see what that relationship is doing to them in terms of their self-esteem because, over time it gets eroded. You know they might be strong wahine to begin with but over time being in a relationship that's not very good.., it erodes it you know, and your self-esteem becomes such that they become the passive members within the unit. Yeah.

Sexual health is related to self-esteem

There's a lot of negative language used against girls you know, 'You've got a big mouth. You're ugly, you're this, you're that' There's a lot of negative messages. And, they take it on board! And, then their self-esteem really drops below ground level. And, so the first guy that comes along and says, "Oh, I think you're beautiful." You know, and sweet talks them. Yeah, they're gone. But, also for male rangatahi as well.

One person pointed out that they were a result of a teen pregnancy and was critical of the FPA's approach to teen pregnancies:

There seems to me to be a family planning perspective and there seems to be a Maori perspective and they don't sort of complement each other. Because, I went to a Family Planning Association Conference, was it two or three years ago? And, they started talking about teenage pregnancies. And, the only view that came across was that it was all bad, bad, bad, and bad. And, I was thinking, I'm glad you weren't successful in Maori communities in the 1960s because I wouldn't be here.

If teens fall pregnant they need a good supportive environment.

It's not the fact that the girl gets pregnant but, as long as it's consensual sex, you know? And, the issue for me is has the young person got the family support around them, it's not that she's pregnant at a young age. And, that's my main issue is that maybe sometimes people do have to consider abortions if they just don't have the family support because at the end of the day it's the child that loses out. What's important is a good supportive environment.

A number of people told stories of close relations falling pregnant at a young age:

One of my cousins, her daughter, was only fifteen when she fell pregnant, and she felt really embarrassed about it. But, that view was in the days. My family, our family said, "So!?" I remember my sister saying, 'He's

only seventeen but his girlfriends pregnant.' So, we just accepted that's part of what happens. But, he also had a good talking to now that he's going to be a father, he has to take responsibilities.

Maori parents can respond negatively to a teen pregnancy but grandparents or other relations can mediate some of the fallout in whanau:

The same happened to my fourteen year old niece two years ago. She fell pregnant and at first her mother was beside herself, 'Oh, what am I going to do?' She rang Nan and said, "What am I going to do?" She said, "You can do nothing but just love her. To growl her and tell it was a bad thing will just push her away, and then you'll be left without a daughter." She goes, "Oh." Nan said, "Do you really want that? Do you really want to have a time in both of your lives where you've parted because you've not seen eye to eye with her being a young mother. Embrace her. And, yeah I don't know. You'll probably have to give your future son in law a good stern talking to about sexual and reproductive responsibilities and the hand he wants to play." So yeah, and she calmed down. It was actually the grandmother who they had to really ring up to discuss the issue through with her first before it even got to the child.

As the child of a teen mother, it was pointed out that whanau do not stigmatise children as readily if they are brought up with other whanau members:

But, because I was born and my mum, my birth mum, wasn't married but that wasn't seen as something bad in my family because, I was given from my birth mother to her sister to raise so, I mean in the European eyes I was a bastard but, in Maori eyes I was just me.

For takataapui tane, there is often a shared parenting role of nieces and nephews:

Because, part of my thinking is that because, I'm not producing any children, I'm quite happy for every other member of the family to do it. So, every extra child is one less child I have to bring into the world. Ha, ha.

Yeah, my brother is doing enough for me.

It is not many years ago that young mothers were being condemned and treated badly in hospitals. Today it can still be fraught for young Maori women to attend education classes or antenatal classes unless run by someone who can relate to the young mothers.

I'm a midwife working with young mums. My role kind of commenced at the beginning of the year to just take on the responsibility of working with mums under the age of nineteen, in South Auckland I care for young mums through their pregnancy and then afterwards as well. The delivery is actually done by the midwives in the delivery suite. So, I take on the responsibility of the continuity roles. So, I'm the main person that kind of is the contact person for the young mums. I have probably about ten to twelve young mums due each month. About hundred or more girls in my books at the moment. I think about 60% would be Maori possibly. But, even that yeah, there's a real mixture of Pacific Island and Maori. Mostly, Maori, Pacific Island young mums. The referrals come from GPs. So, they often find out that they're pregnant through a GP, and the GP sends them.., the referrals through to myself and then I make contact, and then they get hooked into the system here. I have one day a week clinic, and then there's actually a kind of education kind of service that is provided for young mums. So, I don't have a lot to do with that but, I send the referrals through from the girls that actually want to do that. I probably see the young mums between eight to twelve times during the pregnancy. There is a high non-compliance rate. I think the biggest thing is once I build the trust of the young mums and they know that it's safe, that they come and see me, then I find that., yeah, that the maternity care can be improved for them.

It can be hard to deal with young mothers, to gain trust. If whanau support is not strong and there are few resources, the mothers can be just in survival mode.

I think that once I've met a young mum say twice the trust is maybe built, and then they will come back. But, I think a lot of it has to do with the family, lack of family support, lack of seeing the need for maternity care, also just not having transport. A lot of the mums are say aged between fourteen and sixteen, seventeen. Their lives are so complicated let alone having the pregnancy, that the pregnancy is a real small part of their lives. Some of them are very much in survival mode, I guess in life. And, to make appointments, do blood tests and scans and stuff are just another thing that they have to think about.

Teen pregnancies can be unexpected but they are rarely unwanted. The reasons for keeping a baby can be varied.

I think a lot of the mums.., firstly, a lot of them didn't think they'd get pregnant so, a lot of the pregnancies are basically unexpected pregnancies. They're not unwanted pregnancies, a lot of them you know, like yeah.., once they get pregnant they do have a big choice to make, and a lot of them choose to stay pregnant. Firstly, because they don't know what the other options may be or, they don't want to go through that or some of them keep it quiet for quite a long time so, that the family don't put pressure on them for abortions and things like that. There are other reasons they keep it. Some of them know that they were unwanted babies. That they were unwanted and they don't want their babies to go through that so, they choose right from the start to keep their babies, and to become mums. And, a lot of the young mums their mothers or, grandmothers were the same age as them when they got pregnant. So, those are the cycles that are being repeated. So, the major issue is, that a lot of them may be at school or, they've quit school already and the pregnancies have happened unexpectedly. So, that changes the dynamic, it's not a pregnancy that they chose to be in, I guess. So, that changes the dynamic of that. A lot of the young mums are maybe in an abusive relationship where they struggle to find their sense of self. And, still trying to find out where they're at and a lot of the pressure from you know, boyfriends and stuff like that can be quite hard as well.

In some cases teenage mothers are dealing with issues of a lack of whanau and can have been placed under CYFS.

Yeah, quite a few of the mums I look after are actually already under CYFS so, they've been CYFS children themselves. So, they're not you know, they're not from environments that are that you know, healthy I guess. You know, so.., but, think the biggest thing that I've really found is they do want the best for their babies, and they do want to make life happen for them, and they do have goals. Oh, kind of they.., they have some sense of hope in wanting to be good at being a mum and things but.., life is quite tough for them.

Although you may be working with teen mothers on their health, they can sometimes need help with multiple issues such as housing, WINZ etc. Without support on wider issues, they are unable to be a good mum.

It's a huge part of working with the young mums working with social agencies and like your networking with some of the other agencies such as Housing New Zealand to help. provide them with the way to actually be a good mum. You know? Yeah.

When there is a teenage pregnancy it's important to be educating the girls and many don't attend antenatal classes. What this nurse points out is that education in schools does not equip girls to understand contraception or to understand how contraception works. It's only through pregnancy that they understand that there is a choice.

Yeah, there's a lot about education you know, after they've had their babies and even before. Like educating about the whole anatomy of the body, what is actually going to happen in labour, and then afterwards about contraception and stuff. And, a lot of them have no idea about when they can conceive, is there contraception and if there is, how does it fit with their capacity taking a pill everyday or, injection. You know, different things like that. And, how much things cost. So, I think suddenly a lot of the young mums say that they go from being a teenager to becoming a young woman through the pregnancy process. And, I think when they suddenly do that process, they suddenly realise that they have got a choice. And, a lot of these other things, that you would assume that they would know through the school education and stuff like that, that.., they say that they did it but, it doesn't seem to click in.

If a decision is going to be made about a teen pregnancy I would like to think that a whanau would step in.

Abortion

The abortion rate for Maori is relatively high. Asian and Pacific Island rates are higher.

Abortion rates are you know, possibly going up in that age group so, that would be something. Because there is I think, from what I understand, half. Half the teenagers have abortions and half keep their babies so it's kind of very much mirrored, in New Zealand. There's a part of me that thinks these girls that have chosen to stay pregnant are quite brave, and they're actually wanting to make a go of it and change that cycle that they.., you know, they don't want to go through what they've been through so.., yeah.

The point was made that it can be difficult to access abortions because of the difficulties of access to clinics.

There are a lot of protests from the community. You know, especially from the churches about abortion and around the region. For months on end there were people standing out there protesting with their banners and

that, yeah. And, there was a lot of flack in the newspaper. Yeah, so Wellington is still the referral. Which creates barriers for our wahine here. Especially, if they don't have the support. So, there's transport issues, accommodation issues.

Travel to have an abortion if you don't have the support of whanau or someone is also difficult

If they've booked to have the procedure say at 8:00 in the morning in Wellington, it means they have to go the day before. Now, if you're a young student, female student and you don't involve your family they've got to find a way, two days.., three at best.., yeah, to cover themselves so that their families don't know, don't find out.

Adoption

The rate of babies being adopted out is dropping.

There's a lower adoption rate, in the year there's only been one young mum who's adopted her baby out. And, that was a consequence of rape.

They often say it's too hard to stay pregnant, too hard to stay pregnant and have their baby taken from them.

Girls are making the choice to keep babies earlier

I think when the young women decide to stay pregnant that means they're going to be a mother. It seems that decision is made early on now when they first find out they're pregnant.

Issues of transport to access health services is not just a rural issue. Being able to go out to peoples homes is critical for community work.

What Outreach is, is if I've got a baby at home and my husband works all day. He has the only car that we own, I can't get to the doctor, and I can't go and get my baby's immunisations done. Then I'll ring the centre and I say can you send a nurse out to me. And, then they'll send a nurse on the day that suits me. Make an appointment, and come and immunise my baby in my home.

Indicators Of Whanau Wellbeing

Interviewees were asked what they felt would be indicators of wellbeing within sexual and reproductive health.

Communication in terms of asking. If a kuia or a mother or father or koroua or mokopuna rang and said I need to know, people know we're there and they know where to go. I think if whanau can do that, then it means that people are communicating. That would be one indicator of wellbeing. I think the other one would be that we'd like to work in the area of facilitating information to whanau, work with whole whanau's.

I'd say socio-economic stability. Support structures, knowing that you are connected. It's just knowing that you have that whanau support. Part of an indicator for my family would be my sister has a seven year old child. Part of her sexual and reproductive health would be knowing that I'm there to help support her and her boy. Either financially or, just looking after him or her in times of need. I suppose it's communication. The ability to talk about issues or, have that support there, no matter what the issue is. Whether or not it be about relationships or, about possibly unwanted consequences from sex or whatever. Yeah, socioeconomic wellbeing I think is a big one because if you're always looking or thinking about economic viability then you're always on the edge. And, then knowing that you've got the support structures because life does throw curve balls, and it's not always smooth sailing. And, just because there's absence of disease and absence of unwanted pregnancy doesn't mean that that's sexually healthy. People can still have massive guilt's or you know, fear if those things happen, and that makes them unwell as well.

One for me for whanau wellbeing is tino rangatiratanga. They have a right to stand, to empower themselves to make decisions. Secondly, Maori need to be better positioned in the governance of this land. So that whatever the consumer at the other end is needing, it will be provided and understood at the top end to meet that need. The two have never met. Thirdly, is to be a community of non-judgemental, irregardless of denomination, irregardless of gender, that's accepted.

Communication would be the first one, clear, confident communication. From parents to pepe, matua to pepe and from pepe vice versa. Having good communication lines between the two, is one indicator of good health and wellbeing of the whanau. The second one would be role models from those whanau leaders. Having good role models at the top is going to influence those up and coming leaders from the bottom. So, that would play another influence of whanau health and wellbeing. The third thing I would say would be te kotahitanga. Togetherness. Having a good relationship all around. All around you, brother sister, mother father, aunty, uncle, cousins. Good relationships all around. Yeah, relationships, communication and leadership, and role models.

The sharing of information on sexual and reproductive health issues. Information sharing within whanau needs to happen in ways that do not marginalise those within whanau.

The way the information that people have in their families, whether it be from anywhere, from the marae, from the kaumatua, from us, from themselves from their own research, that they could share throughout the whanau. That there is time for whanau to have that quality sort of sharing of information, and about what things are out there. Making a lot more people aware, making their families a lot more aware of things that there are sexual and reproductive health issues. And, on a par that allows all members of the family to have some korero in that. I definitely think that there are principles that the whanau will have in their own whanau about working with that. I think that.., that the practices of that information being shared needs to be appropriate e.g allowing a voice for every member in the family.

Defining Sexual And Reproductive Health

Well, sexual and reproductive health covers so many implicit areas in peoples lives. It's..,, it's sometimes.., it's explicit, sometimes it's implicit, and it just sits behind a lot of the views that I hold about the world and myself in the world. And, so it's.., it's not something that can be just.., kind of put in one little pigeon hole because, it weaves through so many other areas. Self-esteem.., roles, societal roles, all that. It all has sexual and reproductive health woven into it.

Some takataapui discount themselves as part of reproductive health and this is a western notion of reproductive health that a) aligns reproductive health with women b) aligns it with heterosexuality c) aligns it with giving birth. Maori understandings of whanau and reproduction align to whakapapa and a broad notion of whanau and kainga. Our notion of whanau has always been wider than biological relationship, that's why we have been able to adapt the term to non-relation situations. The importance and significant status of whangai for example is illustrated in Takirirangi Smiths work.

Sexual and reproductive health is not quite the right word, it's more about sexuality. When you say sexual and reproductive health, it does put a parameter on it because, it's talking about the wellbeing of your sexual health and your reproductive heath. So yes, I think that's much more defined so, whether or not you define health as being life enhancing or free from illness that kind of covers things.

Yeah, which goes more into people's sexuality because we're all sexual beings from birth until death, and maybe beyond who knows? And, maybe before, who knows? It influences how we interact with other people. How we see ourselves, how we project and protect ourselves. And, like I was saying it feeds into things like self-esteem and then that feeds into whether or not risk taking behaviours or, abusive behaviours.., and yeah. So, sexuality is one of this things that sits behind and sometimes it sits in front of what we do.

I think, nationally, most people would see sexuality as being of what orientation you are. Whether or not you are maybe sexual or not, like expressing yourself sexually, usually with another person. And, I think sexual and reproductive health tends to be defined around the absence of illness. So, sexual health being not having STDs.., ah, STIs or.., and reproductive health would be around the capacity to be able to reproduce. So, not being impotent or, not having fertility problems.

I understood that we had that larger view of sexuality which, incorporates sexual and reproductive health but, being able to see it in a much bigger and broader picture. So, we dont just get into being focussed on disease prevention and also condom use. That, we expand people's awareness, and our own. Our sexuality is so much

broader than just what we do with our genitals. Our service delivery was a framework that incorporated more than just sexual health. So, it incorporated what society and culture or, how society and culture influences our sexuality. The relationships of all types that we have and how they can be shaped by society's constructs and norms. How we see ourselves, like our self-esteem and that self esteem or, how that projects into our relationships and also how we influence and are influenced by society and culture. So, it brings it away from just sex, and sexual health condom use, and disease prevention. When we're working in schools that is their prime focus because, it's the most obvious thing that we see. Either someone's got a disease or, someone has got a.., pregnancy. Yeah, yeah, yes. But, I think that everyone is trying to locate sexuality.., in relation to their own personal experience, their perceived thoughts about Maori sexuality, and responding to some of the bad statistics or, the statistics that show Maori have more pregnancies and STIs. Yeah.

Range of views from Maori in response to sexuality

Yeah, yeah, so finding somewhere to place themselves so that they know how to go forward. And, that partly was what came out of what was happening during the conference in 2004, the first National Maori Sexual and Reproductive Health Conference. These people wanted to find a common way of understanding sexuality, and some of the issues that Maori face in sexual and reproductive health.

There are a range and diversity of Maori educators

You have lots of people working in sexual and reproductive health but that doesn't mean they were all thinking the same thing. It doesn't mean that they all came at it from the same world view. And, therein lies some potential conflicts or misunderstandings because, people don't really want to say what their views are just in case it contradicts somebody else's you know, traditional view or, their personal view or, their studied research view. I think generally, we're not reading from the same hymn book, as it were.

Its important to understand the diversity of opinion within Maori communities

When people bring out tikanga then if people aren't really strong in it, it can really pull them back and throw them. And, there's nothing worse in Maoridom than someone saying, "Ah, but you don't know. In Maoridom, or in my iwi…." That's a power and control thing. That's a really difficult one to navigate because sexuality it could be a biological topic, a sociological topic, it can be an anthropological topic, you know, it can be taken and studied so many different ways and from so many different angles. And, it's also incredibly personal. So, if you talk about.., I don't know like, the social construction of sexuality and.., really, you're talking about it from an anthropological perspective. But, if someone has lived that and you're trying to say this is how you've been constructed to think like that. That can be quite damaging as well or undermining.

Diversity extends to ideas about the whanau.

Because, to do that you have to consider that the traditional romantic, the traditional traditional, the traditional colonised views, the kind of where we are today.., and then the stance that our.., that we took on particular issues or topics or, whatever.., it's a huge task to kind of do that kind of work. Because, it is recognising the diversity.

But, if you look at it, just sexual and reproductive health then, nothing really. Not much at all. So, I think it goes back to your first point about what is included in the area. However, having said that there is, I think, as a part of the takataapui research literature there is a literature being developed around sexual and reproductive health.

The importance of whakapapa and increasing the Maori population was emphasised

Well I think firstly about identity and whakapapa. I think that needs to be entrenched because as a race of people, and our population is really dwindling because there's all the different cultures coming in, and you know, so you're getting all the 'half'a cassy' and all the different getting in there and it doesn't help when a lot of our men are in prison. So who's out here reproducing? Our women. Ok, so it's so important that rangatahi need to understand about what it is to be Maori, how do you create Maori, you know, and so if it's going to happen in a way that they're not going to break the law and do bad things, but that they are going to be productive in life and multiply, at least there's some understanding there to support them in terms of the importance of whanau, the importance of whakapapa. And I suppose it also brings back that monogamous, you know, about not having too many partners, you know, in terms of safety in regard to all the different STI's and HIV out there, you know it's kind of done to you, you know reproduction because of all the fear and that.

There's all this move to 'rubber up,' you know, and if you're going to do that, again it's going to take a toll on Maori and our population. So again it comes back to whakapapa, it comes back to making our children aware of their identity, aware that they need to reproduce, you know, for their own existence, and doing that safely.

The importance of spirituality was mentioned.

And, I think sometimes when sexual and reproductive health is talked about there's this notion that all parts are connected and we believe in the holistic but actually, they're not articulated. So, it's sort of like it's a big mixture but, you don't actually give value to there is a spiritual dimension. There is a sexual dimension, there is a.., an erotic dimension, there is a physical change. You know, that those things aren't actually.., they're sort of blended in and I think that's one of the areas that we need to be talking about is that when you're talking sexual and reproductive health you are talking many things other than just a baby will be produced or, an STD will result or.., the physical manifestation of it.

It was seen as important to understand the 'bullying' culture in sexual encounters.

I think though we do need to unpack the fertility argument. I think the damage of chlamydia, the impact of sexual behaviour that's unplanned, the fact that there's still a bullying or sexual violence with relationships where contraception is seen as.., whatever, layers are put onto it, that a condom is.., you know it's not a natural thing to wear a condom. It's not a.., this isn't the way it was meant to be. That sort of pressure is still put onto young girls and I think the risks are not ever explored.

Sexual and reproductive health includes whanau, hapu and iwi

It includes a lot more than what I initially set out to think. And, that's thanks to a lot of people that have been stalwart in the area of sexual and reproductive health, you know. Whanu, hapu, iwi is a term that's used quite a lot. And as much as it's used a lot it doesn't mean that the mahi is actually getting there, you know?. I think sexual and reproductive health from comes in as part of other areas to work with, when you're working with whanau, hapu, iwi.

Health includes the persons confidence in their own sexuality.

To me personally, sexual and reproductive health or, sexual health is a persons overall sexuality, if that makes some sense. I mean, it's not just whether or not you're a girl or a boy. It's not just wether or not you're heterosexual or homosexual. It's everything to do with a person's sexuality. So, be it off their gender, be it off their sexual orientation, be it off their sexual preference, their sexual behaviours, what they like to do in bed and stuff like that, they all differ. And, we're all unique in our own way, and we all have the right to our own choices. Yeah, and so I think sexual health is made up of all these things. A little bit of everything. And, it makes up you as an individual. Kind of like Te Whare Tapawha. Te taha wairua, te taha Tinana, te taha hinengaro, me te taha wairua Yeah, well e Tapawha. Those, all those four things make up a healthy body. Same thing with the sexuality I'd say but, it's got more than four.

Takataapui Issues Raised By Providers

Sexual Health Promotions

Sexual and reproductive health messages are mainly targeting rangatahi and to be more effective they need to be culture specific, factual and developed as a multigenerational strategy, i.e. not just focussed on the rangatahi.

There is a need for media messages and promotional material to be more culture specific to engage Maori effectively. One thing coming through is that to put the message across effectively it has to be Maori. When you do posters and you're going to show STI's or, ure [penis] and things that have been infected like with warts or crabs, use a brown skin. If you show only white skin, Maori will go, 'It can only happen to white people.' You know what I mean, it's that visual thing and it's got to hit home. It's like, 'Hey, that's one of me.' Then that really hits home. And it's messages like that that we need to be providing.

We see a lot of the educational stuff around sexual health. I've seen some with young boys playing in a skateboard rink with some music in the background, they're about 15, 16 and they're just skateboarding. Then it's just words like 'going to be safe' and other words like that. Children today are far too advanced to be getting a message out of that.

The gay community organised and lobbied effectively for service provision for HIV AIDs sufferers in New Zealand.

I think that the HIV AIDs one is quite interesting because, I think the gay community in New Zealand were particularly vocal, and were able to lobby effectively for that kind of service provision.

So, no I think it was more the whites or the Pakeha gay community who were politically out there.Maori have got so many other things to consider. I wouldn't say basic survival but, it's the things that are right in front of you that a lot of Maori have to deal with. So, they haven't got the safety of a comfortable lifestyle to be thinking about other things. Survival, and then if you're ok then it's probably your whanau that is needing your support to get them selves sorted.

Promotional messages should be part of a multi generational strategy. A complete campaign from children to adults.

What you show to adults, you need to be streaming that down to a younger age. I mean, hey, they're locking our kids up at 12 because they're murderers. A lot of our kids are promiscuous at a young age too. And if we don't meet that gap we're going to have more problems.

Within the takataapui community itself the name takataapui is still being debated as to its appropriateness.

I think that we do need to look carefully at the term itself and assess whether it is the appropriate term for describing gay and lesbian peoples as there is some critique emerging around how we define ourselves.

Some gay Maori men are not comfortable using the term takataapui

I think within takataapui there's a lot of individual interpretation on what that means. And, sometimes it's a term where I almost feel like I could be challenged on it because how can I say I'm takataapui if I'm not really, how do you measure this because I'm not really Maori.

Takataapui in rural areas lack support from both whanau and government agencies.

Rurally, again, the lack of resources. Keep watching the cows, ha, ha. You might see a gay bull. I would say everyone knows about gay men because, there are a few in my community, and we respect it but I suppose not the word takataapui. So, that kind of stuff, our home people still have to catch up on what's happening in the cities.

Queer was a derogatory term

I remember the term queer. And it had real bad connotations in the 50s and 60s. Now it's used quite casually. I wonder how the gay men of that era considered that. I would consider that to be an awful term myself but at the end of the day, it is our thinking that is changing. And I think it's not hard to turn people, if they remember, one; that they're Maori, and two; that the person they're talking about is their own whanau. And yet they would be the very first one to stand up and want to bash someone up.

The history of Homosexual Law Reform in the 1980s saw the emergence of a stronger political stance by Maori and pakeha. But Maori had their own identity and expressed it through developing the label takataapui. The history of this battle needs to be told. Today there is a new political climate.

The political time is different now and so too are the reasons for that staunch identity as takataapui, as gay or lesbian peoples. It's born from way earlier from my memory of the 80's and the Homosexual Law Reform Bill and stuff like that. If people weren't staunchly out then and staunch in believing 'I'm lesbian and that's it.' Homosexual Law Reform would never have got passed actually. Now those people are in their late thirties, and into their sixties.

It's interesting how the politics have shaped our sexual beings and therefore the way that we need to approach sexual and reproductive health.

With disappointing HIV statistics, AIDs Foundation workers are looking for ways to also engage and educate men from the communities, outside stereotypical gay male haunts.

I think we're doing ok, but we could do a lot more actually, just in terms of engaging with our community.

If you're a gay Maori man then society puts you in a box. You only go to these venues; gay clubs, gay venues, gay parties and stuff like that. But, then there are also the other places, which men who have sex with men who do not identify as being gay or takataapui, frequent. So, we need to go there.

I think we've done quite a bit in terms of reaching out to our members. The statistics in terms of HIV incidences are not too good, certainly in the last three years it's not been good.

The Warriors for Safe Sex poster launched by the AIDs Foundation received controversial responses from Maori communities around a perceived breach of tikanga.

The launching of the takataapui poster really brought people out of the woodwork and identified for us the real kind of antagonists; People who aren't in support of what we're doing because poofters can't do the haka basically. The response was similar for the Kauae poster [A poster depicting two Maori males with moko kauae on their chins, traditionally a female customary practice] when it was released. I guess the fear is we're tampering with tikanga. We're trying to alter tikanga.

We are Maori, we are Tangata Whenua and we have every right to express ourselves in our cultural form. I was asked by Willie Jackson during a radio interview, 'Did you ask for permission from the masters to perform the haka?' The main reason I didn't consult was because I don't bow to them, and I have my own masters, they had given me the permission to carry on. That's a new urban thing the need to consult like that because they don't understand their own culture sometimes.

After we'd put this out I spoke with a cousin of mine and she'd seen it. She emailed me and she said, 'Well, cuz I think you're right, the haka is a form of debate. And what you've actually done has inspired people to say their piece. You've encouraged debate. Obviously, a lot of what is coming back to you is negative, but that's fine. That's what you wanted and they took the bait, hook line and sinker.' And, I mean it produced coverage for us, I think about a hundred thousand dollars worth. For free. It didn't cost us anything.

Whanau

Takataapui youth are not finding the support at home.

There's no support at home. Whanau are turning a blind eye because they are ill equipped to deal with their young ones coming out.

Age-old attitudes at home are often the first barrier whanau need to overcome in order to support their children.

My first husband was dead set against same sex attraction you know, males. And, I said to him, "What if we have a child that is attracted to another male?" "Oh, no, no, no. We won't have one of those in our family, I'll disinherit him." And I thought, 'Hey, you've got to open your eyes to the world.' He goes, "No, God made male and female. He didn't make male and male, and female and female."

So, these are some of the old age attitudes that are going around in our homes.

Whanau want 'whanau focussed information' not individual counselling in order to support takataapui members and each other through the coming out process.

The help services for takataapui are based on the alienation of people from their whanau, not a wholistic approach to whanau. I think the urban attitudes are influential in individualising policy responses.

If we had someone who could have worked with us as a whanau after my brother came out, and say this is the information, it would have helped the healing entirely. So that's why I believe that the strategy is actually whanau, it's facilitating information so they can make good choices.

Whanau members are very supportive of takataapui

My father, my uncles were very protective of me when I was growing up. Especially, when I got into my secondary school years. Sometimes, I'd act out kind of queen'ish, and at other times I would try and conform to the way that my uncle's would act. But, they didn't really blink much of an eye at me.

I remember they used to get me to drive them to the park, things like that, and every night they would have a fight. They would just end up fighting for no reason. But, one night they fought because they heard some other men saying, "Oh there's that little faggot that hangs out with them."
"That's their nephew aye?"
And they go, "Yeah that's their niece."

And, they were laughing, ha, ha.

But, my uncles didn't think it was very funny. They really couldn't laugh at themselves my uncles, and they didn't like people making fun of the family. So yeah, the jokesters often perished. Yeah, and it still happens today.

Homophobia interrupts the traditional solidarity and constancy of whanau. Many takataapui and their whanau struggle with attitudes of homophobia when mainstream ideas replace traditional Maori knowledge.

Changing whanau attitudes of homophobia is the act of restoring Maori thinking to the whanau.

He came out and he was saying that his family is still struggling with that. And he's been out for years. And it's the girls that have become more critical. And he says, they forgot he's whanau. And they treated his sexuality as an issue. And that's why working with whanau is important. It's actually about that restoration of Maori thinking. Whanau is whanau. You are my whanau regardless of whether you are gay or not gay.

Takataapui are working in a wide range of areas with whanau and for whanau.

The greatest resource for us is our people. We had a hui about three weeks ago with takataapui from all over the country, and most of them are leaders in their own right. Twenty years ago we sort of started that seed we're growing today.

Over the last twenty years all of us have sort of matured and taken on more responsibilities in our own whanau. So, when we say something these days our families actually listen. Those takataapui at that meeting all had similar responsibilities. Some of them work in health and some of them carry the kaupapa for us and when they say something their people listen.

It appears women are more comfortable with coming out than our men

So generally we're finding our women are coming out but not the men. Not the men. And it's simply because of the confidence within the whanau.

There's a perceived higher risk for men too eh? Because they're more likely to get beaten up. And I think it's still happening here in Wellington, it's just not heard about so much. Just a couple of years ago we heard of a young boy that was.

Takataapui are a whanau and older takataapui should support younger takataapui to help find and maintain their identity.

Again there's the identity, there needs to be peer support. There needs to be older takataapui to be there to awhi the younger ones that are coming through.
We need to adopt the role as the mother and the father for younger takataapui.

I work right across the board because, I will not have children so I mahi other peoples children, kaitiaki them. Sometimes those children can be in their sixties. And that all comes in because of the hinengaro. That sixty year old is not up with it so, you be there to care for them.

Takataapui Visibility

The visibility of wahine takataapui is extremely lacking. Wahine takataapui issues, concerns, and community, are often overshadowed by media focussed concerns of the Maori gay male community and the Maori heterosexual community.

There is very little available for wahine takataapui that I am aware of. There tends to be more of a focus on the issue of HIV/AIDs in the Maori gay male community and sexually transmitted diseases and pregnancy, and related issues amongst the Maori heterosexual community.

I think there may be a general assumption that Maori lesbians are at less risk and therefore there is little if any education or discussion in that area. Recent media reports on HIV/AIDs stated that they are not aware of any lesbian transmission but I am of the view that the focus on AIDS as a 'gay' disease has really meant that very little discussion has taken place about much else.

Takataapui visibility continues to grow.

The AIDs Foundation has done their new promotions for Warriors Against HIV [Warriors for Safe Sex], and that was a good stand for takataapui and for The AIDs Foundation.

The TV programme Takataapui is beautiful, beautiful to see Maori gay and lesbian people on TV talking about their lives. You know, not for anyone else, not for society to feel sorry for them, just to hear their words. So, I think it is growing steadily, and I really look forward to the future of takataapui.

Over the past ten years takataapui issues have emerged in academic literature, the political arena and the media.

The whole takataapui area, academically the literature and that sort of stuff has just emerged over the past five to ten years. So, it's like a new literature as well. There is also a politicising if you like through literature, through takataapui literature coming through. There's quite an extensive, not a huge amount relatively but there's a growing takataapui literature out there as well.

With the takataapui research there is a developing literature coming out. You know, you've got voices like Clive, Leonie, Jessica, Pania, Ngahuia, all sorts of different writers out there. There's a development. Even within the takataapui literature area you've got a diversity of writing out there. You could even see in there Maori writers, such as Witi Ihimaira.

Takataapui In Schools

Takataapui and sexual orientation is a very limited part of the sexual and reproductive programmes in schools.

We sort of like have one that focuses on that. Probably, the only time that we do come across it is when the kids are getting smart about it. So, then we dive into takataapui and all that sort of stuff.

The session is set up to give them a little bit of insight into how the life of a takataapui.., all that sort of stuff. There's a lot that comes out of that session.

Takataapui issues remain a very small part of sex education programmes in schools. Students wanting more information have to request it or, find it elsewhere.

It's definitely part of our korero you know, takataapui. With these peer education programmes I need to say that it's a module in one of the parent programmes and it's a topic that comes up in our delivery of information to the support groups, community workers and all that kind of stuff. Yeah, it's part of the package. We like to think that we take that value about respecting difference with us wherever we go. And, we like to install that in the young people we work with. But, when that question is posed to us.., we have a good network of other agencies. We will sit down and we'll talk about it and we'll just basically flag what we know, with the young person.

Ministry of Education released a resource to support queer youth in schools. This resource has not been well received by many conservative schools who believed the resource was unnecessary.

Well, in the schools there was that latest resource that came out in late 2004 from the Ministry of Education. And, it was about supporting queer youth in schools. We facilitated the bringing of a health promoter from down in Wellington.

Yeah, it wasn't very well supported or very well received. A lot of our schools are really quite conservative, and so they don't believe that they need to have those sorts of resources. They haven't got that problem in the school around same sex attraction, and yet there has been identified in some of our kura, in our high schools, girls kissing girls in the corridor.

Takataapui youth have become suicidal from the pressure they experience in schools.

There is peer pressure around girls in the locker rooms with other girls. So these things have been identified as a bit of a problem and they need to do something about it. But, the schools are saying, 'No we don't have that problem in the school.' We even get to the point where we have young males who become suicidal because of the pressure within the school.

It is still not safe for rangatahi to be out in schools.

Takataapui policies in schools are also not clear and schools sit on the fence. The Ministry has a pilot running for safety in schools for queer youth and we need to find out more

> *While the school will sit on the fence, they will blanket the policy. It will sit under the Bullying Policy or, if they have a policy around discrimination or, sexual harassment. You know? It isn't a policy on it's own. That's why schools aren't buying into the Ministry's programme. Safety in schools for queer youth has been piloted around the country so, we're hoping by next year we can get a pilot here in Whanganui.*

Conflicting beliefs that youth sexual orientation is changeable is a contributing factor to the lack of support for takataapui in schools.

> *You know statistics say that by the age of thirteen-fourteen you actually know which sex you're attracted to.*
>
> *I guess sexuality isn't really settling down anyway until the late teens, early adulthood, yeah.*

The point is also made that it's still not safe for teachers to come out. So how can youth feel safe in coming out?

> *I think the schools if they happen to have staff that identify as being gay then, yeah, there's an interest. But, once that staff member leaves everything just collapses in the middle.*
>
> *This problem has actually been identified. There's been a couple of women that moved to Whanganui, teachers, that won't say that they're lesbian because of the environment in the school.*
>
> *The staff are a good gauge themselves for the school and so, if they don't feel safe then they won't disclose. Then it's not safe for the students.*

Closet Space is a new initiative in Whanganui.

> *It's actually for same sex attraction like male, female, transgender, takataapui, gay, lesbian, bi-sexual, people aged from thirteen to twenty-four. It's got a youth focus and it's going to be run every fortnight.*
>
> It's got policies and procedures in place and we've actually got an agenda that we work by. It takes students through sexual *health, it takes them through diversity, it takes them through police diversion, it takes them through what is being gay. It's actually a really good programme that's run from within Lesbian Gay Rights Association. And, we're actually under the umbrella of that at the moment but, what we're hoping to do is over the next twelve months become our own identity*
>
> *We had our first meeting on Monday night and we had two people that participated in it. We have a male and a female representative. Why we've got male and female reps is so that they're safety nets for each other. And, one of the rules for the reps is that they're not allowed to hit on the rangatahi that attend those groups. They're solely to do the workshops with rangatahi, getting them to talk about their own sexuality, and it's confidential.*
>
> *We don't put into our flyers where the meetings are held, if people want to attend they have to either text or e-mail, and the reps go out and visit them in the community. They go out and have a coffee with them. They don't take them to the Centre because they've got to check them out just to see if they're for real, they could be gay-bashers for all they know. They'll have a talk with them, get their details and then they'll let them know where the meeting is to be held.*
>
> *There's a young girl that's helping me do it, she's an excellent resource. And, the other person that we've got on board he's a real out there in the community person. Between myself and this young girl, we chose a guy who was out and the rangatahi love him.*
>
> *We've actually started up Closet Space, and we're hoping that the resource person will come into the schools, and that we can get it into the health promoting schools. We're going to try and come in and do some policies around queer youth in schools. This will hopefully get teachers and other personnel on side. So, those youth that are being bullied know exactly who they can go to, and they can use the policies and procedures to their advantage.*

Barriers To Learning

Mainstream Programme Requirements

The programmes are developed within traditional mainstream views making them difficult to expand.

> *Just having the background knowledge to say this is where we're coming from is a constraint. Because the programme has only been developed in one way we can't say, 'Well this is a traditional view and this is another view, and this is another and these are thoughts or ways of being in the world. Take your pick.' We can't really offer that so, what we've got is a programme that is going to be quite difficult to expand.*

The traditional mainstream views are maintained.

> *During the course of negotiating our contract with the ministry I said 'Well you know, we really need to start incorporating a Maori worldview.' And this woman said, 'I'll tell you I've been in sexuality for a lot of years, rangatahi don't need to know and they don't want to know that.'*

Accessing Communities

Access to other ages and groups is difficult.

> *Whanau have a different perspective, Maori have a different perspective in terms of how the message is reached. Population groups and target groups need some serious whanau ora approach.*
>
> *We're trying to get to an older group, and Maori communities want us to deal with all ages.*

Access to young people is dependent upon school timetables.

> *General constraints are the time allotments in schools. Being able to access young people.*

Provider staff changes can alter established working relationships with a school.

> *It is the job of the longest serving educator to develop the relationships with the high schools.*
>
> *Well, it's changed over time. Initially it was the manager then it was the senior educator and now it's become the responsibility of the peer educator.*

A change in the schools contact person can again require working relationships to be re-established.

> *It varies between the Health and Physical Education Head or, it may be the Dean of each year. Or, it could be the Maori teacher, depends on the school. And, not only the schools but it may be coordinators of say the private training establishments or community groups or whoever.*
>
> *Some schools opt for outside groups and some prefer to do it themselves. And that's when the relationship issues are brought right up into our faces because we'd been reliant on the one kind of venue for so long.*

Contract loss.

> *We were able to go along from 1998 to 2003. So, about five years just working mainly in the one school, and that was fine, it was easy to maintain the contact. Then they decided they wanted to do the sexual education delivery themselves.*

Religious Beliefs

Religious beliefs can be a barrier to the learning.

> *There is a lot of information but it just doesn't seem to be getting in.*
> *There are just a couple of kids that come from religious backgrounds and all that sort of stuff. It sort of cuts what we're trying to teach and it cuts them off from us. They're learning about sexual health and contraception and whatnot and it's just a big no-no in that arena. That's something that comes up a lot when we go to schools especially with a lot of Pacific Islanders, and Maori too.*

Some faith-based sexuality educators have problems interacting with rangatahi

One of the faith-based providers had flak from Sexual Health because they didn't know how to interact with the kids properly and get the messages across to the kids. And that was raised in a parent meeting just last week.

This is one of the key things that comes up in the western thinking, how do you communicate in youth language?

Promotions

Promotional material and messages must be right.

With the approval of our Board we boycotted a poster put out by a Maori provider. It just wasn't consistent with our practices. It wasn't the sort of message that we wanted to be sending our rangatahi. It's about condoms and lubes go hand in hand, one without the other don't work. They said it was about getting the message out there but it's getting the right message out there that is important.

It would be worthwhile some of these big Maori kapa haka competitions getting behind supporting the use of condoms. We understand that over in Wiggin or somewhere they've got some soccer team that's actually saying, 'Score well, use condoms.'

Provider Capacity Is Limited

The information is limited.

Whether we like it or not we've limited and we're limiting, the information, the right information our rangatahi need.

Delivery is limited.

With the rises in HIV and what has been coming back from the community forums is they want to see more of a presence, which also leads us to how many takataapui will be out there or present at events?

Teaching can be limited.

There are major constraints because they ask you to explain things that you wouldn't normally think about. So, you just do it. You know like, some of the questions are like making you explain how do you breathe.

Staffing is limited.

Because of limitied staff and limited capacity we don't have a very big reach. There are just not enough sexual health educators.

Administrative Requirements

Providers need to have the skills to complete audits, reports and approvals, etc to meet funder requirements.

I left school at the age of 11 and that paper work stuff is aawwhhh for me, hands on doing the mahi is more me. Sister had an education so she knows and we learn what's required of our funders as we go, meeting the approvals and all the auditing, and all that kind of thing. For me, that hinders what I do but it has to be done and I guess it's about the needs and it's about consistency. Actually it's huge.

Maintaining Working Networks

Gathering for meetings and organising venues.

I guess other constraints into our mahi is encouraging people to attend meetings. That's always a huge kind of task every year or whenever you want to have a whole meeting, whether it be with non-Maori or Maori. It's always a mission.

Sometimes it's not seen as being appropriate in terms of where we hold the meetings for Maori, some people haven't let go of the past in terms of HIV Aids.

Evaluation Of Providers

Some providers have initiated evaluation processes to improve their future performance.

We contracted a university team to come in and do an evaluation on our sexual and reproductive health programme.

We wanted to initiate our own evaluation on ourselves. I mean it allowed us to use the recommendations that came out of that to go forward and to use those recommendations to guide our strategic plan.

Rural And Urban Differences For Sexual And Reproductive Education

Rural areas lacked resources

Lack of facilities and sexual and reproductive resources is the biggest thing. I suppose the generation before mine, growing up in the little country bumpkin town that I did, would have had no exposure to sexual health. I think the closest you would get to sexual health then would just be people getting pregnant.

At that time Sexual health issues weren't known of not even when the local doctor came. I think the local doctors and nurses in my generation started coming into the schools when I was about seventeen. So, by then you were already on your way out.

The differences between rural and the city is the resources are there in the city whereas, they're not so much in the rural areas. In rural areas you have to watch the sheep and cows.

In my little community it's ninety nine point nine percent Maori, all of us are Maori. We didn't all speak the reo some of us did and some of us understood both languages. So, the tutors at the time taught it to us in English and we would probably just translate it into youth words. Into our words.

Rural areas need the services too. They need.., I think the only need the organisations that are based here in urban areas to be taken out to the rural areas. I don't know how but, it should be, maybe a mobile bus. Yeah, a bus taking out like the Air Doctor I think it is, goes around in a mobile bus. The flying doctor! Well, we would be the 'Flying Educators!' 'Sex in the Air'. Or something. Yeah, Sex in the Air. I think that's the need.

Whanau support is greater for rural families

There's also a difference between Maori living in the rural community and Maori living in an urban community. If you're a young, single mother, the urban responsibilities to provide all the determinants of health for your child falls on your shoulders. Often the whanau support is there, and mainly through a phone call. Of course, if you can't afford the phone to maintain that contact it is very, very restricting for that mum, in an urban community.

In a rural setting the whanau home is kind of like the marae, so you've got a lot of people interacting and coming over and checking everyone is genuine about the care of that young baby. It doesn't matter that they're living alone.

Every Maori community, any Maori community whether their Christian values come through, 'Oh, well you should have been married first and then had children.' You know kind of those whakaaro. But they do understand that at the end of the day it's about looking after the next generation. And, so they don't want to lose the mother because there's that, that, that link straight away and they want to maintain that. So, they'll support, and awhi that.

Personal Experiences Of Sexual And Reproductive Education

What emerged in the research was that there was little sexual education happening in homes among whanau when the educators were growing up. Their age ranges were from early 20s to late 60s.

My education was gained through research but experience was my real teacher.
I got my education through my own research into the topic as I was growing up. I was takataapui or, I identified as gay when I was about thirteen. So for me it was learning about what that meant pre-homosexual law reform days. And, trying to find out what the feelings that I was having meant.

So that was really through looking up stuff at the library. That was probably about the main sexual and reproductive health learning I got. I got very little at school, very little from the whanau, from the family. No, it was probably only when I was about sixteen, seventeen and came down to Wellington and started living a gay lifestyle.

My sexual education was gained inside a culture of sexual abuse.
It was kind of an erratic time in my life when I first found out, as I was sexually abused by an older person, same sex. Having left home at an early age and ending up on the streets at the age of 11 so, to survive out there one had to turn tricks. So one became quite aware of sex and what it was all about at a very young age.

It was a crash course. In the home it was abuse, out on the street was the same type of abuse only you were paid. And I guess, at an early age being young, dumb and full of cum, you know it's like, you were just exploring. But, you're also being abused and used, not only by the client but also by the street mother who saw young, fresh meat. You were told by your street peers what you do and what you didn't. So I sort of learnt from that culture about sex and all that.

My sex education came from my parents and my school.
Well, it was my mum and dad actually. They would talk to me about sex and sexuality but along the lines of hetero normality, right? So was like, you're coming to an age now where you're going to see a girl or, you're going to like a girl. But, at the time I knew I was a girl and I was interested in boys. That was at about nine years old.

The formal kind of education around sex and sexuality and reproductive health didn't start until I was about thirteen, when I started going to college. Understanding puberty and all those types of changes and stuff. So, the first encounter about sex and sexuality in terms of education was from home.

My sex education came from my cousins and the other kids at the Pa.
I was at the Pa and, I think I was about five, six or seven. I think I had a general understanding back then because, after school some of the older kids used to go down into the bushes, and people used to say, 'Ooh, they're kissing.' 'Ooh, they're having sex.' 'Ooh, they're doing this.' So, I think that's where I sort of understood that there was something happening between boys and girls.

I remember my cousins telling me this joke when I was really young. It's like there was a Maori girl and her name was Whakahaara, and her father said, "Don't let any one into the house when I go off to work." Because she was a pretty young thing, she was a teenager.
So, one day her father left and Whakahaara was at home by herself and the milkman came. "I've got milk to deliver."
And the girl said, "I can't let you in because dad said you're not allowed in."
And, he said, "Come on, I'll just pop in."

And, so Whakahaara let him in and then they started playing around. And, the father got back some time later, knocked on the door because he left his keys behind and, the daughter wasn't opening the door. And, he tried it about three times and then he yelled out "Whakahaara! Whakahaara!"
And, the milkman said, "I'm trying to!"

It was a bad joke but you had to understand what was happening and I learnt that when I was about five. And, because I was so young my cousins used to tell me the intricacies of it, and what it actually meant. So, I learnt

quite young about sex. It is quite a young age to know about sex at five or six years old. I think it was always happening around us, sex and sexuality and stuff but at that age I just wasn't interested in wanting to know. I just wanted to be a kid.

Obviously, there's the sexual mechanics of it all, I suppose that's basic. But, I think each family has their own way of talking about it. Although, we get really slack about it between the generation before me and my generation.

My mum never really talked about sex. I think she just thought because I was a boy I could go out late and get up to more mischief than girls could, because if girls got into mischief they came back pregnant.

Whanau And Individual Rights

Lawful rights

A case in point for me was the Civil Union stuff. Tariana Turia said she couldn't support it because when a takataapui died family had to have the right of access to the body. When the Civil Union came into place the whanau would have that right taken away from them. So, I mean I think that that's a point where some Maori people are holding on to the past.

Whanau rights

At the end of the day that's where whanau come in, our old way was that the whanau had the ultimate say. I don't necessarily disagree with that but because of the merging with Pakeha and other cultures it's about negotiation now.

If someone in my family fell pregnant it would be nice if they asked me my view but I don't think that they necessarily need to if they wanted to have an abortion. If that was right for them then I can't stop them. It's not my right to, it's my right to actually support the decision they make.

Individual rights

If I disagree with something I definitely have my say. I suppose if I disagreed with something I'd have my right to have a say. I'd definitely have my say. But, that's what I view as my right, it's not my right to tell people what to do.

My sister made her choice by expanding the family line. Which is her viewpoint as I see it you know, the continuation of the family line but I don't see myself as needing to do it.

Rights of takataapui couples and whanau

The rights of the individual are really, really important to homosexual relationships. And, for Maori couples it's really important that whanau understand that the individual make the decisions. And, that the whanau need to stand by and respect that.

In terms of tane moe tane relationships the rights of the individual and the collective are very important, myself and my partner are also important. We had to make that clear with our whanau and they understand that.

Whanau and individual rights extend into wairua and whakapapa.

There's stuff that we don't really talk about because it's really family knowledge. And even though I can talk within my family about the mechanics of sexuality there's some private stuff too.

For some families they feel that when some couples are joined together it's wairua that brings them together. And, I think that's something that we can probably touch upon in some things but it's not for general consumption.

I guess for as long as I can remember Kaumatua were talking about destiny and fate in terms of wairua. I remember these Kaumatua sitting together late one night like old mopoks and they're sitting there talking away, bubbling whakapapa and wairua and stuff like that. Next minute their conversation veers to the stars and the

heavens and they're talking about how they were meant to be, it was written in the path of the stars and if you look there and there, and they were linking them up. But, that knowledge is gone. Those people are gone and you're right, it's not for general consumption. You'll find masters who actually know it, and you have to be careful where they come from.

There's more awareness around whakapapa now. It's sort of come back. It sort of slipped away for a while.

Tomo was an old custom. It was usually done around the time when there was a mate. Back home after the tangi there was always a drink up, and if our kaumatua saw any boy or girl playing around, he'd tomo them, marry them. That put an end to the mate by having a marriage.

Then you can look at it from another perspective, kaumatua might see that mokopuna there and remember that mokopunas tupuna, that girls tupuna, and they see that boy over there. They're not too close but they knew that boys tupuna, and the characteristics of both of those mokopunas tupuna. So kei te tomo ka hoki mai ano, that kaumatua, I roto mo nga mokopuna. So there's the coming back of that tupuna again. You understand what I'm getting at?

So within that process, comes that monogamous relationship, the purification of the pedigree. If we want to save ourselves from becoming extinct, that could be one of the things that we need to teach, is to bring back the kaumatua and kuia process of finding the right mix.

Whanau And Individual Approaches To Sexual And Reproductive Health.

Individuals

We have to think about the individual first, look at ourselves first especially concerning sexual orientation. We have to know inside ourselves whether or not we are homosexual, transsexual, bisexual, heterosexual, etc. So, working those kinds of issues out has to come from us first. It's from there that you grab the support to make that decision from your whanau.

Whanau And Individual

It's gone from individuals, to two-parent families, nuclears, you know, when you start breaking it all down then you lose one another. And that's what it is. It's the survival of the fittest. And really that's not our make up. It doesn't matter how hard you try, along the way you're still lonely because your seed is not a sole seed. So you know there's been some sad Maori I've known over the yearsexual and reproductiveight up until they are 70 they've kept away from Maori things. And when it comes to their time, it was a lonely tangi. And it's sad because of hi choice, this kaumatuas choice, that all his kids and his uri don't know their other side because he's made that choice as an individual. He's made a family, he's made a genealogy line and they follow after him. Now you've got programmes on Maori Television, these kids trying to find their papakainga, because of what their parents as individuals made decisions. And it's affected their lives. Why should our children suffer? Let them know who their whanau is. Don't let the word Maori, the stigma around Maori become, you know, you're embarrassed to be a Maori. Because that's what's been in the media and everything out there, oh if you're a Maori you come from this line of no-hopers. And yet we have the key, we have the tools, we have the answers. You know but we keep on getting trodden on, trodden on, trodden on.

Whanau Education

Whanau education is more than just the parents, education can come from a wide range of people and generations.
I think that's all mainstream, and I don't think there's enough Maori in this particular area. I think it really needs to start within the home. And I think our kaumatua and kuia and parents need to be educated. You know, because they need to open up more because if the child is not learning in the home, they will go out on the street and learn. And that's a worry, you know, because that type of learning is that you actually experiment to learn, whereas in the home it is te korero, te whakarongo, you know, and that's so needed. The one that needs to be educated here is our kaumatua and kuia. More so the kaumatua

because it's all this thing around taboo but I find that the kaumatua are more open to reach to the mokopuna. But there's always been that gap between the two but the kaumatua also have a nice way of coming across to the mokopuna. You know and they can see more in terms of the urgency whereas the parents can kind of just 'ah, shut up' and just cut it off just like that and that's really sad. And not only that, I think because the kids are always every-day-mum-and-dad, or whatever, there's always that confrontation. There's less of that with the grandparents. It seems to be the trend today where our tamariki are being dumped on our kaumatua and kuia, you know, to care for them. You know I think it's really important, even the marae should be a place to teach that. Because within the marae it has our whakapapa there, you know. How did that whakapapa get there if it didn't do the act? You know, so it's there within the whare. It's all the reproductive, it's all there, in the whare. All the stories. Kua puta mai kua mea, you know, that whole thing about Papatuanuku and all their children. It's all there. The reproductive health is all there in the marae. Take it back. And I want our kaumatua and kuia to tiaki them, the marae, the Mauri of all that, you know for the mokopuna.

Whanau

> *I often work along side the mothers, like the young pregnant woman's mother. So, the family circle is really important because they're often unaware of what's going on as well, and what's available. Quite a few of them then take all their daughter's off to get the Depo you know so, it's working with the whanau really.*
>
> *I'm urban, brought up in the city. I work in the city, and I'm very aware the influence and the strength of whanau and the approaches that family or an individual can take towards sexual and reproductive health and how it can determine the rights that are there for them.*
>
> *I'm thinking the whanau would be more inclined to notice the rights of themselves and their tamariki and their rangatahi, if they were more a part of the korero and they will be inclined to be a bit more open or, proactive.*

Wahine responsibilities for sexual and reproductive health.

> *Wahine have had to deal with the issues of sexual health more as they are the ones to get pregnant. With high levels of single parenting, women are the ones raising the children so they need to be educated to pass the information to their children.*
> *It's just left to the wahine to sort out and that's usually it nine times out of ten. It's from within the family and the community that they are able to support their girlfriends and themselves through issues of sexual health.*
>
> *I know, I know. This is the 21st century, hello! I know. But, it's been right throughout the ages, women have always been left to deal with the issues.*
>
> *Women have always been left to deal with all health. You know? That has to change because a lot of women would have had partners or husbands, and so there was that relationship going on in the household. Today we have a lot of single parents male and female but predominantly female and f they don't have a lot of insight and understanding in terms of their own sexual health, how can they share that with their rangatahi?*
>
> *I know my sister's quite different because with her children she's taught them about sexual stuff from an early age. You know, just the mechanics of it all. And, now that her children are teenagers and they're getting involved in sexual stuff she's now adding the extra dimension of, 'people's emotions.' That even though you might have protection, you can hurt people, you can get someone pregnant, and maybe you don't want to carry through with having the baby, and all that sort of stuff. In my family it's mainly the women that discuss all these sorts of things.*

Learning Through The Generations

Our parent's generation

> *When I reached seven, I had to go to another family member after being with my grandparents for so long. So, I went and stayed with my dad's eldest sister who had three girls. They were very much teenagers and quite active in their social life, and quite sexual in how they interacted with boys. I also noted that around similar kind of family discussions my aunty never spoke about sex, and sexuality, reproductive health, it was always the girls who initiated the conversation. And, neither of the parents were wanting to engage. They would just turn a blind eye.*

I think I was just lucky because I had an open mother, she didn't teach me about the penis and vagina and stuff like that. What she did teach me was that if I was gonna go and have a root, the condoms and all that kind of stuff was at the back of the door in the bathroom. So, that's the teaching she gave me.

I think my mum and my sister probably had a different relationship than my father and I did. I think my mum and my sister talked a lot on sexual stuff maybe, because they were both female.

Our grandparent's generation

An increase in parenting by grandparents means there is an older generation who can be less aware and open to talking about sexual and reproductive health issues to rangatahi.

We now have a lot more rangatahi that are actually being raised by their grandparents. Again it's about knowledge, grandparents don't have the knowledge or if they do have the knowledge it's from what they remember.

With their grandparents, with your grandparents, even with my own parents we were never ever taught about sexual health. It was a forbidden word! It was tapu.

Our generation

When we got our period it was just given a cloth and not knowing what to do with that cloth. You know? It was never ever explained to my generation but with my own children I've actually taken them through the steps of puberty. I don't want them to grow up ignorant.

So, it's about us as parents now giving our children the knowledge and the skills for their own safety. That's what it's about really.

As parents we do know, we've got experience in this. So we mightn't have known at the beginning what puberty and sexual health was all about, but we do now as adults. So, it shouldn't be a problem for us as adults to teach our children.

Barriers to whanau supporting each other

If you're brought up in a family whose norms are drug and alcohol and it's become a second or third generation problem the rangatahi is not very well supported.

It isn't a priority for the parent because their priority is putting bread and butter on the table for the kid, and if they're not working it makes it even harder. It's not a high priority for a lot of parents that are in that sort of mode.

The other thing too is parents need to identify for themselves what the communication issues are. I have an adolescent, a rangatahi seventeen year old son and I tend to be a bit of a bull at the gate with him. So it's that communication thing. It's about relationships. It's about negotiation skills.

Risks for whanau who choose not to educate

When the responsibility for sexual education is avoided, whanau members will be taught by others, gaining others perspectives, values, and understandings

What I saw when I was living with my aunty was that the information coming into the household wasn't from an adult perspective, it was from a teenagers perspective. It was from their mates, their peers talking about sex and sexuality. So they taught me quite a bit about sexual and reproductive health.

With regard to family roles and sexual and reproductive responsibilities the question is who takes charge and who leads the way and stuff like that? Is it meant to be tuakana, teina kind of stuff?

It's meant to start at home and I guess it does, but in different ways, and it comes into the home in different ways too. And, again it wasn't until I hit formal education that I was told 'the' way. In inverted commas, sexual practice and stuff like that.

Suggested solutions

Communities can support whanau to be their children's first teachers of sexual and reproductive education.

> *Yeah, that's where our nurses and that need to come in and do things. Even the schools need to be bringing in the whanau, bringing in the parents, our nurses and our Maori providers doing talks with them around sexuality. So, that they can actually deliver to their children.*

There is a need for sex and reproductive education to go wider than just rangatahi as parenting is also an issue for Maori.

> *Because it's a busy world you know, idealistically it's not going to happen. If we work in terms of whanau first then, I think it needs to be generic so parents learn to have a broader perspective of what parenting really is. Then work with parents in terms of the growth and development of rangatahi.*

Education needs to start young.

> *You know, I actually think it needs to start right from the time they go into their first crèche. The resiliency skills need to be built then. The silver spoon, everything that comes into it needs to be built in those first few years and then carried throughout their childhood, careers you know, growing and developing.*

Funding And Contracts

Accessing Funding

Funding is a key issue. Without funding there are no clinical or educational services. Funding can come from the Ministry of Health (Public Health), the District Health Boards or through…

> *Our main contract is really with the Ministry of Health. We're very fortunate that all my predecessors were really, really good in terms of funding. We're supported by the Education contract at the moment. We're looking at increasing that in January. We've been looking at a couple of ideas, one of the ideas is about creating a rangatahi forum.*
>
> *We're funded through the Ministry of Health, we're public health funded and there's a couple of contracts there, and basically our mahi is to go out there and inform young people of the health issues that exist.*
>
> *Funding criteria has reduced the outcomes for sexual and reproductive education to the prevention of disease and pregnancy. So, it's a fraught area and and usually it comes down to disease prevention, and pregnancy, and prevention. And, then there may be workforce development for those working in the area.*

Contracts and interagency ways of working

> *When social workers actually get contracts to work with families Ministry of Social Development and Ministry of Health may work together. So, maybe contracts with MSD might need to be accompanied with MOH, Ministry of Health contracts as well.*
> *Providers say funding for sexual and reproductive education is limited or patchy and subject to change*
> *They will have their bottom line. Going right back they didn't fund the adult education and they reduced the funding for youth education.*
>
> *There was a certain level and then it increased and now it's gone back to what it was. It hasn't really gradually declined, it just had a good phase and now it's gone back.*
>
> *When I came into the organisation we had a look at the books, at the time our manager and the Board had only been able to crib together funding which was for one-off activities, and the amount of time that was being spent reporting on those tiny, disparate funding streams didn't make sense in terms of moving forward.*

The funding is not always responsive to providers changing needs.

> *What was unfortunate is that there was a low service delivery period, we had a high number of educators and then once the business had been picked up, the funding had been cut so the number of educators came down. So, it's a bit of an unfortunate turn of events.*

In order to justify funding you have to identify in what way you are different from other providers
We have the funders again exerting their power and control and saying there has to be a point of difference. Because we're seen as experts in Maori sexual and reproductive health, what is our point of difference? I think, we are Maori but that's not quite a convincing enough argument. We can say we can provide programmes in te reo, which was probably the main argument for them. But, from our side of it because we are by Maori for Maori and we primarily advertise in Maori we think if we get it right for Maori then everyone else will get it right as well. But, you can't really sell yourself on that.

The state of working relationships between funders and the providers can often be hostile

The Ministry was hostile to Maori providers in general, and in that sense our organisation had a hard time. I was lucky in that when I came in I could see the problem and at the same time there was a change in the Ministry staffing, because of this new combination of factors I was able to secure proper funding. The contracts manager at the Ministry was also a person I'd worked with previously, so we had a good working relationship. I was able to build on that.

We got to a point of, 'Ok we've been doing well lets have some mutual exchange and get things going.' Then that soured and then that really went sour. And, then I think in my time I was basically sidelined because I was nobody of any consequence.

On top of that, the sexual and reproductive health sector is minute, and sexual and reproductive health is not one of the top health priorities for the Ministry. So I think that that compounded the problem. Our manager was able to discern information from the statistics and they worked hard to try and get the Ministry to see the extent of the problems in sexual and reproductive health for Maori, but the Ministry at that time didn't want a bar of it. I think that was part of the hostility.

The counselling is ok, that comes through CYFS and I think we can get more from there. It allows for so many hours with our worker and we'd like to have more hours but I don't have a strong history with CYFS and the Ministry of Social Development. So, I've yet to kind of really think about how I can access a lot more from that area for our organisation.

Focussed funding

Our contract is peer education and we run services for youth health, youth sexual health and all that and I think that's ok in terms of funding. I say that because other guys are less fortunate with their funding and I need to be respectful of that. We do have a lot more than others.

Fragmented funding

People might get funded or contracted to work with social work and then while they're working with the family economic circumstances and then educational issues and social issues and sexual and reproductive health issues might come about.

I have to say the sexual and reproductive health sector is more than kura, more than the community, it's whanau, and it's hapu, and it's iwi. Those issues are partners with these other issues. They're all a part of each other. And, if we understand that then we can better work for our community. And, this is actually another funding thing, it's fragmented funding, 'You do that bit, you do that bit, you do that bit.'

There is competition for contracts.

I know that we used to go into the colleges around the area but, Regional Public Health got that contract and it's kind of not our job to go into the schools any more.

Contract restrictions for providers - Providers are restricted to the defined terms of their funding.

Our service is defined in terms of our funding. It's defined in the way of our thinking though, you know? Our thinking is, and we've had this dilemma mai ra ano and I'm probably speaking for a lot of others when I say that we go in and out of the class and we know that there's take behind the scenes. But, we don't go there because that's not our area.

Like now when we talk, I'm thinking of the wider context. But, when the mahi is full on then, I would say what our funders have contracted us to say.

Working outside contracts - At the invitation of whanau, providers are working within their kaupapa but outside their contracts.

We've been asked to come and help with whanau situations and we have on occasion around pregnancies. Because of the couple of situations that we did work in, we see our role as a lot more proactive in terms of attending to whanau meetings and talking about sexual and reproductive health issues with young people.

Yeah, well the thing is we're contracted to deliver information. But, when we come up with these ideas around work with a whanau that's seen as intervention. And, we're not contracted to do intervention but we might be caught up because of the relationship and the rapport we have.

I can't drop them off just because oh, my contract ends. So, there are things that we work outside the contracts but definitely within our organisations values and guiding principles. Still within our kaupapa.

Maori educators will try to go the extra distance to make contact with Maori pupils.

If it means that I can at least reach one or two of our Maori rangatahi I'll do it. The iwi will, they'll do drug and alcohol and so,I'll tag onto them and usually I'll do a little mental health component and I'll also do a sexual health component as well.

Interagency Collaboration And Networking

In order to go into schools and to run courses a lot of time is spent networking and developing relationships, linking to other Maori providers etc

The DHB, is about education but, it's more about networking, having key linkage sexual and reproductive relationships with other Maori organisations, schools and agencies, doctors, hospitals, the Ministry of Justice, the Department of Corrections, corrections officers, etc.

Every term we hold a sexual health meeting, and the majority of the providers in Auckland will be there, Attitude, Rainbow Youth, the New Zealand Aids Foundation. We discuss how maybe they can help us and how we can help them. And, that's another way we get a lot of our networks.

I have really good relationships with is a group working out of Nelson. They provide stuff around sex and sexual health awareness and they use wakaama, group dancing performance and expressions to get their messages across. And, there's Kia Piki te Ora, the suicide prevention programme for Maori.

Some networks are used for interagency training

We've done HIV Aids Training with them every year. We go up there to get our resources because HIV Aids and sexual orientation is part of our programme. We get all those kinds of pamphlets, it's really cool.

A number of providers saw the need for networking as important. The area has developed in such an ad hoc way that it needs to be consolidated. Sharing of information such as resources, teaching styles, funding sources, etc would be invaluable.

The development of kaupapa Maori training needs to happen. Sexual health providers are not working together, they have very little contact. Some people think that the other providers do but they don't have contact.

When I say regional collectives, I'm thinking of all those providers, all Maori working in District Health Boards with sexual health portfolios. There are also other NGOs that have sexual and reproductive health contracts. So it's all those people I mean to come together and the Aids Foundation, it would be mean.

When we were organising the conference we wanted to support those Maori that worked in mainstream because we needed to tautoko those ones. So working a lot more collaboratively I think. There is a collaborative where a lot of the agencies came together for the sexual health kaupapa and created the PHAT Pack. It's not Maori, it's everything. It's Maori, it's Pacific Island and it's Pakeha. Yeah, so it's all coming together.

The process of being on a marae is an opportunity where you usually get up and say who you are, where you come from and who you tatai to in terms of your marae, maunga, your hapu and things like that. Those are strengths.

People sitting in that room, they may live in Te Wai Pounamu but, they might actually have whanaunga from the far north or in the east and west of the island, and that's all part of networking and engaging. And, so they'll come up to you afterwards or straight up they'll stand and say their piece. And, the next thing you know, by the end of the hui you're sitting in a group and you're old cuzzies. And, in terms of breaking the ice, that's how we've managed to maintain our links, is through that forum. It's and art form. We are so good at making links. But, I think we listen differently too. You know, we actually do listen for the links whereas, I think Pakeha have sort of already judged and condemned before they've even got there.

Advocacy

Providers are very aware of the future impacts of current issues and advocate preventative change even though their efforts appear futile.

One of the roles I see is attending a lot of the Maori partnership hui, DHB's, and attending the PHO's to say, 'Hey, sexuality and reproductive health is important to us as Maori. Our worldview around this is such and such and it impacts on whanau. So what are we doing about it?' While they may not listen the thing is we put it out there consistently.

We've generated a lot more support now because we're not talking about condoms, but saying, 'Hey, we have issues here and now, how are we going to address them?' 'This is an issue for me in my area, what are the issues in your area?' 'What do we really need to do as a Maori collective to start addressing this?'

We could be saying the same thing in 10 years time and by then our numbers would have tripled. I mean HIV is moving at such a rate that it's not going to stop because we haven't got a strategy in place. And that's why it's important to be more proactive in our thinking.

Links To Mana Whenua

We didn't identify any providers that had particularly good linkages to mana whenua or hapu and iwi. If people working within the organisations come from the local iwi they were considering how to make the links otherwise they operate independently. There is some work to be done to look at how to work with hapu and iwi.

I actually think whanau don't come together enough to support the development of iwi, because iwi make all of the decisions but then they have lost contact with the hapu. Hapu have lost contact with the whanau. And you may get a representative from three families going to the hapu level making decisions for twenty families. Then it gets to the iwi level and so it's fragmented all the way up.

At this time there is very little work done with iwi and hapu. They are busy on their own issues unless people are involved with hauora issues.

I think it depends on more than the individual. We do have to take into consideration other factors that involve this person, and this involves this community, this whanau, this iwi.

I don't know too much about work provided specifically for sexual and reproductive health to the iwi or, to the hapu. When the land claims happen there's a lot of people who are working with hapu and iwi, it's more about those kinds of issues like getting their manawhenua back and that.

I guess our way is to find the champions in there that have their hand up for the hauora issues.

Whakawahine Community

I feel my community, the whakawahine community, are the last off the rank, the taxi rank. You know, and come on, get your mind off out there sucking cocks on streets. You know, you get left behind girl. You know like after

25 years out there on the street, you know, it's like, hey, it's passed you by. Because a lot of us chose our sexuality. And because our sexuality and being in a dress, in those days you couldn't go to school. So we chose to be women and gave up our education. But it was also, I see it as our resistance, our political stand. Our statement, part of our commitment to takataapuitanga. We took the blows because we stood out, you know what I mean? Whereas gay boys could blend. And while they were blending, they got educated. So I always ask our gay boys, 'Hey, don't forget your sister here.' You know, come back and awhi us, we were the ones that got the blows. And with those blows it made a little movement forward. It made the path. But at the same time, I took that traumatised life and made it a positive one that whoever comes down that pathway, I can stop them. Or find a better way. Try and encourage them, 'you don't need to go there. Go back. Things are getting better. It won't be long and you'll be wearing a dress in school. You know, things are starting to change.' If not, then let's create that environment, as of right. So our whare, our office, there was a takataapui, young transgender, maybe 13 or 14, we would get her correspondence or get some education. Nah, you sit there and do your mahi in this whare. Carry on getting that education, as who you are. Because we need to be pumping out our doctors, and our professors, and our, you know. They're there but never been given an opportunity to blossum.

Right now over here in the States, where the old guy that did all the sex change operations, he's retiring in his 80-somethingth year. But he's done hundreds and hundreds of sex changes. He's handed his legacy over to a doctor that's had a sex change. How do you like that! That is a succession plan. A sex change doing sex changes. She's adopted a son, she's got a husband, and now she's a doctor. She's taken over from this guy. This guy, this old fella, he's well known, a famous fella who's done sex changes, this whole town knows what he does because all the sex changers go there. Well his predecessor, the one that's taking over from him is a sex change. Not to forget about Georgina Beyer but you know, that's that political area.

Rongoa

In terms of the clinical/medical side of sexual and reproductive health we need to look at rongoa Maori and natural remedies. That needs to be explored more because I'm frightened of the different types of pharmaceutical stuff that comes out that's getting put into our children. If we go back to the sixties we had all these deformed babies because of certain things. That I have a problem with.

We can look at the alternative, natural remedies for our tamariki, you know natural birthing. I'd like to see more of that coming into the mainstream or coming within the PHO's. When you use the rongoa you don't just use the rongoa alone, that's the secret of our tohunga, of our people, of our culture. It's just not one alone because atua has to be a part of that.

So if you are the practitioner you have to live a certain life to be able to deliver. If you're giving the rongoa you also give the karakia, you also know what needs to go with that. It's also about being able to convince the wairua of that person to be positive. And it's an art form to convince another's body to heal.

Racism

I can remember as a young boy walking along the streets of Kaikohe with my mother, and she had my baby sister in her arms. Kaikohe Library had a little office to the side of it this was being put up by Plunket at the time. And, this is where mothers could take their babies to breastfeed. I says to mum, "Oh, I'm sure the baby's hungry, you should go in there and feed the baby. It says you can go in there and breast feed.'"

My mother says, "No baby, we can't go in there." "Why not?" I said. "Because it's not for Maori parents, it's for Pakeha parents." That stuck with me. As a very young lad that stuck with me and I felt, "Oh, well bugger them, let's go round to aunty's place." For Maori when children are hungry you feed them, that's it. Society has taught us that in specific circumstances it's wrong to do that. A lot of the attachments between mothers and their children have been lost in those early years of child development because of those laws and the stupid things that happened.

The racial stigma of Big Maori Families saw many families targeted for aggressive contraceptive programmes. The trauma suffered by those families has not faded for many Maori families today.
I think historically, contraception was used against us basically. It was used for social control so, you got Maori families who were hammered for having children too young, and for having big families, too many children. Yeah, now when you try to talk about contraception you've got to work through some of the real trauma around contraception. Maori whanau were bombarded for so many years. Controlling our population aye?

Social Control

Economics has always been used as reason for particular populations to use contraception

I guess it comes down to what's economical, what the economic drivers are. If it costs so much for a young woman to have a child and receive social welfare support or something like that as, opposed to a health prevention messageyou get an organisation like Te Puawai Tapu to deliver some programmes. Then hopefully it's going to have an economic..,

It's an interesting and economic.., yeah, an economically. And how much is it going to cost the country. And, I suppose the lead on from that would be wanting to protect society's up and coming economic producers.., well, who will be contributing to the economy of the country. Focusing on and ensuring that they prevent.., maybe from having children, la, la, la, la. Those sorts of things.

An economic driver, which is always around us.

There is a huge focus it's just easier to focus on disease, infection and behaviour rather than what attitudes lead to the behaviours.

Traditional Romantic View

It goes back to that traditional romantic, traditional colonised view. And, I think it's hard when you're trying to see sexuality in its broadest sense. Then they can pull the programme into something that's narrower in its definition and in it's scope.

The initial development of the programme was done in conjunction with people who had an idea that it needed to be more unrestricted and, much more about helping young people to develop their own ideas about their sexual and reproductive health.

Developing Maori perspective sexual and reproductive health programmes

And, again I think that background homework to know where we come from on particular issues or, about Maori sexuality, Maori sexual and reproductive health in general. I think it's like any operation or, any business when it expands it's got to be working properly on that smaller level. Because, when it goes bigger your problems just multiply.

And successes. Yes, yes, yes. So, if you're going to bring people in then they're going to be coming with their ideas and their world views, and unless you can say well this is our view..,

This is our foundation.

Yeah. And, we have thought about these things but, this is what we're choosing to.., put out into the community.

Adults

Maori rangatahi are easily accessed in schools but finding large Maori adults…

It's always harder when you're working into the more mature age groups to be able to.., find a place where you can capture them. School is easy, they have that period put aside for health so we can also access the highest number of Maori students.

Problems With Statistics

There are problems with the collation of statistics. For example the conducting of a pregnancy test is not confirmation of a pregnancy. Sexual and reproductive health workers question the data on teen pregnancies.

I get frustrated by the stats that keep coming in about the high teenage pregnancy that we have in this region. Well, where? Ok, we see girls who suspect they're pregnant so we do a basic pregnancy test that comes back negative. Well, that's not teenage pregnancy.

I might get a student that's positive and they might go and see the counsellor and have a termination.We don't know where the stats are actually coming from.., these high rates of teenage pregnancies. Because it's not really all collated very well is it?

We have a pregnancy counselling service here, they collect their stats. We.., but, then the young woman who decides to continue with her pregnancy.., you know ok, she's a teenager who has a baby but, that doesn't mean to say she doesn't have support you know? So.., ok.., But, they're talking more of the unplanned pregnancies for our young rangatahi, you know?

I think we're restrained in our funding and our resourcing but not our thinking. Our acknowledging of the wider context only gets tapped into now and then.

Mainstream Teaching On Sexual And Reproductive Health Is Not Working - Policy

He is saying that the Maori model or Maori way could be applied as a teaching across the board, this will help others but it doesn't help, you have to believe in the origins of the korero otherwise it doesn't help.

A suggestion was made that Maori ways of teaching would be beneficial for all.

I think that the actual dominant way of working with sexual and reproductive health at the moment, isn't working. You know the dominant way, the one that society agrees with. It doesn't matter if they're Maori, Pacific Island or Pakeha, I think our approach is more holistic, I think Maori ideologies are about working holistically, everyone should be able to benefit from Maori ways of working with hauora and, in particular sexual and reproductive health.

The policies around youth'anising those approaches should be more accommodating to allowing us or, allow people to come in and provide sexual and reproductive health from Maori perspectives, and when I talked about compromising we wouldn't have to do that if the policies and the culture that was developed at the top end would fall down through the schools and establishments that we access.

Respecting the Tinana - A story was told about how the delivery of the programme changed when a kuia told them that the programme needed to include respect for the tinana.

We welcome feedback from our kaiako, and one day after a session this kuia pulled us aside, she talked with us for about an hour. She said, 'You fellas you are talking about this and this and this. When you talk about cleaning the tinana, why not talk about respecting the tinana?'We did talk about the reproductive systems. We talked about the vagina and the penis and stuff like that but, she turned it to respecting the Tinana, which was great.

First Maori Sexual and Reproductive Health Conference

For the Conference we pulled together a national working group of Maori from across the sector to make sure the Conference represented the needs of the whole Maori sector. We pulled together Maori people from around the country, there were 7

people, I think, on the national working group and we met each month for 8 months in the lead-up to the Conference. We planned the Conference theme, the workshops, did funding applications, everything as a group and it was a very, very good. The Maori sexual and reproductive health sector that drove that first Conference. And that's how it should be.

> *And I think coming out of that, the health reforms and the competitive contracting environment, there was still amongst our people the possibility that we would be seen to be trying to dominate the sector or trying to take contracts from other people and we needed to make it very clear that that was the last thing that we wanted to do, that we didn't wish to seek any additional funding or position ourselves in any way separate from other Maori organisations. And I think again we were successful. I'd say my measure for that was the amount of trust that was built between us and the other Maori providers and the support from the other providers for us to take a lead, which actually I didn't want but that was what we were being asked to do.*
>
> *I was aware that just because we were the organisation with the biggest contract in Maori sexual and reproductive health we couldn't assume that our reality was the same as others.*

It was pointed out that education wasn't the only thing necessary for change, that societal attitudes also needed changing.

> *I think the first thing you need to do is change the attitude – attitude is across the board. Be whatever level you look at it, it's the attitude. And that's what we need to change is attitudes. But we're in this society today and if we take a glimpse at what's happening with our rangatahi, what's happening with their parents, there could be three, four generations of DPB but within that environment you have departmental people in housing – WINZ, all the different government agencies, that have got a grip on our people. And when they're not functioning properly, there's going to be a break-out. Let's look at the twins (Kahui twins incident), that was an overcrowded house, it was Housing NZ. Those two twins were part of a triplet. Why was it that when they were released from hospital that there was home care. So that's another department that failed. You know what I mean. WINZ, you know, not enough. Employment. Why aren't they employing our Maori? Everyone else gets a job but Maori. Maori seems to be a stigma. So attitude, ok. That's the overall thing that I can put it down to. We can go into it and break it down where the hara is, but it's attitude.*

Mentoring

> *We have a kaupapa about developing young people, and I think that adds to the fact that I like to have young people working because that's our focus, and that is what has added to the FTEs that we have. So, when I say it's not well funded it's because, not to the approach that I would like around FTEs and stuff like that.*
>
> *Well, I grew up with my grandparents being the eldest son of the eldest son, and in a house basically dominated by males. My father's brothers were all living under the same roof and all the older sisters had their own families. So for a major part of my life I just saw male interaction and sexual displays, the ways in which they would approach girls and you know, sometimes they were a bit rough. Sometimes they were a little bit too rough.*
>
> *And, then when we are given the opportunity to sit down with the masters of whaikorero and whakapapa it just goes in one ear and out the other because people can't relate to it. The marae experience is no longer seen as important as it once was, and it's just a fabulous time for the family to get together. Say farewell. And get drunk. And procreate. Huh. Not all the time. But, you know.*
>
> *Our main aim is to prevent the spread of HIVand that goes hand in hand with our promotions. About two, three years ago we had a national takataapui hui, and takataapui Tane it's doing a Campaign preventing the transmission of HIV . and a lot of it's networking throughout the whole country, and doing workshops. Yeah, so we provide our workshops ..?.. we hook up and say, 'Hey, we want to come into this region, want to come?'*
>
> *Because, the gay stuff is still not easily received by Maori ..?.. Used to us over the last two hundred years. But, we still have to be quite cautious about some of the stuff.*

But, I know an initiative from Te Puawai Tapu earlier especially, when Alison Green was in there, was to take on responsibility around HIV Aids prevention. And, also her karanga was .., her calling was for other organisations to do the same. But, still today they're the only ones doing it. Which is fine.

I got funded through Tariana when she was in office with the Labour Party and it was the Closing the Gaps Funding, so I'm still a survivor from that. Everyone else has fallen off but me. But Pakeha soon catches up on the good work that Maori try and do, and try and bring it down. So I've made myself associated with another organisation that's run by a Pakeha, and I let Pakeha deal with Pakeha.

You deal with that, just let me get on with the work I do.' Why? It's because they can't do it. So in one way or another I'm quite lucky. Although they're starting to get the manual out of me. Then I'll become redundant and obsolete. But that's fine because hopefully what they're taking from me, they can reciprocate in other areas. What I do now with the mahi, it's going to awhi elsewhere. And I'm fine with that. It's not mine to own.

Talking Policy

The sexual and reproductive health area is contentious in policy. Policy is influenced by the international context of sexual and reproductive health and by different groups within New Zealand.

Unfortunately, sexual and reproductive health statistics show that Maori are disproportionately affected, having high rates of sexually transmitted diseases and more teenage pregnancies at a younger age than non-Maori. Maori Providers in the sector identify a number of barriers to the implementation of sexual and reproductive health policy and service provision for Maori.

Ministry Of Health: An Overview Of Sexual And Reproductive Health

The Ministry of Health has overall responsibility for sexual and reproductive health in New Zealand.

The Ministry of Health holds overall responsibility for the sexual and reproductive health area. The ministry sets the direction for sexual health services and has a team that works on sexual and reproductive health issues. The sexual health team meet annually and plan the Sexual and Reproductive Health Strategy for the next year. As well as reviewing existing contracts and assessing priorities, they also monitor the sexual and reproductive health contracts to make sure that what was planned is actually carried out, ensuring the contracts are in line with the strategy. The ministry also has to respond to ministerial questions. The ministry not only funds contracts and monitors them they also manage a set of contracts both national and regional.

The ministry only funds so many contracts. There are maybe twenty to thirty Maori ones under public health in the ministry. The clinical services are funded through the District Health Boards and there are a number of Maori providers contracted through DHBs, through marae clinics and other areas. The DHBs fund all the personal health services e.g sexual health, heart disease, etc. DHBs provide clinical services such as treatment and checks, and tests. The government devolved all the funding for those services for each DHB, for each district. They didn't devolve public health money, which is still managed by MOH.

There are some key documents relating to sexual and reproductive health.

The Ministry of Health makes reference to the Sexual Health Strategy, the Action Plan, the Sexual Health Resource Book, and the HIV/AIDs Action Plan. Policy can also be set by the DHBs and if there is anything then it will be included in the district annual plans. The MOH has set key goals, such as reducing the incidence of STI's in communities.

Sexual and reproductive health is the second priority area for the Public Health Directorate.

Sexual and reproductive health for this financial year has become second on the list for the Public Health Directorate.

Yeah, so that's the Public Health Directorate, so it's the second highest priority so, there should be more movement on it but you've got to remember is that, like we've had a huge problem with tobacco and cancer rates, and so for the last three years they've topped the list. Every bit of money, every new development has

gone towards the highest priorities. So, there's been cancer, there's been tobacco, alcoholic youth, alcohol and drugs, you know. And for sexual health, because there haven't been any big issues happening, and you know how many health issues there are, it hasn't had as high a profile. This year it's moved to number two. That's good. Although, that's not public, you know? Because people wouldn't like to know that things are rated but they have to be. You can't work on everything.

Approximately 80% of people are accessing sexual and reproductive health services from their GP, not from Maori or mainstream providers.

I suppose there are a lot of things to do with sexual and reproductive health; one of them is also part of reducing inequalities, which is work that we do. And, even though they're not directly related, they do improve sexual and reproductive health, is the increase in the number of PHOs. The number of Maori that registered with PHOs increased dramatically once we had all the access issues sorted out.

Oh, and the other thing that you need to know is that most people, this is like 80% of all people, access their sexual and reproductive health services from their GP. All the services that we fund, you know that the DHBs fund outside of GPs, only pick up 20% of the work. So, if you're thinking about sexual and reproductive health, you really need to find out what GPs are doing because they're the ones that do it. They do most of it. You know, they do most Maori too, believe it or not.

When it comes to accessing clinical services, very few Maori do that with a Maori provider for sexual and reproductive health. Also, Family Planning has very low Maori numbers that go to them, very low Maori that go to them for their checks and things like that. They are picked up at some of those youth clinics and things like that. Yeah, but youth clinics they don't really want to be the place you go to get your pill, you know. So, how many Maori GPs are there, you should ask yourself, around? I mean lots of providers will complain about GPs. They'll say, oh you know, they'll end up with clients who were embarrassed by them or, you know those are the sorts of things, didn't like the service that they bought but, that doesn't change the fact that they get most of the business. They don't solicit for it, people go to their GPs.

Sexual and reproductive health in a policy vacuum

I think there's currently no legislation on the books that vaguely represent sexual and reproductive health. Probably the closest that came to it was Sue Bradford's Corrections with Mothers with Babies Bill. You know, about the rights of babies to be with the mother but you know nothing else.

And, then when there are Bills about sexual and reproductive health like Georgina Byers Bill, or the Marriage Clarification Bill that was last years United Futures Bill, they're all conscience votes. So, in terms of where policy has gone they become seen as a personal conscious choice of the MP. So therefore the Party doesn't have to have any policy on it. Therefore the agencies don't have to do any policy work on it. And, because of that the people don't raise policy issues about it. You know?

When I look at all the correspondence that comes in, I can't think of one letter that's come which says we need to raise the profile of talking about sexuality. So yeah, it's like a big silence. The policy vacuum, it's a bit depressing isn't it?

I know when we came to the first Maori sexual and reproductive health hui last year at Seatoun [First Maori Sexual and Reproductive Health Conference held in 2004], in terms of where the government of the day puts its energy, that's been about the only focused anything to do with sexual and reproductive health for years, and that has been through the work of Maori providers out there. I mean that was all Te Puawai Tapu's initiative, and public health people.

Sexual and reproductive health policy is fragmented. When you separate out the groups you have risk groups. All the policy is about managing risk. But also the Ministries want to tack on the Maori perspective and don't want to centralise it.

And, I think for sexual and reproductive health it's the same thing, the moment we start saying it's a teenage pregnancy problem and you forget about the Nanny that really wants that mokopuna, then you've lost it. And, yet Ministry of Health will insist you look at the teenage pregnancy problem, you look at the women who are infertile and you call them another category, and you look at the STD stats, and you look at the chlamydia stats, and you sort of pocket them into risk groups.

And, sometimes that's appropriate that you work within the communities, the Men Who Have Sex With Men communities will have certain strategies, but in Maori circles you just can't break out to age or to gender or whatever. I think the greatest problem with working with Ministry of Social Development, with Ministry of Health, with Child Youth and Family, is that they want the Maori perspective but they don't want the Maori framework. So, they want you to give them the title and a few concepts. You know, or talk about Hauora for instance, or we'll use the Whare Tapa Wha models and say that we've got it but they don't actually want to conceptualise it or understand it.

Policy to direct their work is sorely missed by on-the-ground workers. They feel that the Ministry of Health considers sexual and reproductive health a low priority area and this translates to low priority for the regions. Workers felt the absence of regional strategies, in some areas this is being pushed for and developed by the workers in the field.
The thing is we haven't really got a regional strategy. With the sexual health network that we're a part of we're actually trying to get a regional strategy for the region. We've got a national strategy but nothing for the region. It's not a high priority for the DHB.

But it's not even a high priority; sexual health is not even a high priority for the Ministry.
No. And yet it should be.

I'm not surprised that the Sexual and Reproductive Health Strategy has gone nowhere.
I'm not at all surprised the Sexual and Reproductive Health Strategy has gone nowhere because it was going nowhere five years ago, and it became too complex. The discussion at Ministerial level about where it's going, they were extremely angry that Tariana Turia had said it's not a problem. It made the headlines, you know it created bad press and so they stopped talking about it. Sexuality is a positive feature of life, we should talk about it. But the agencies don't want to listen to it.

And, I think that the fact that it's been in health has been the problem because it's been too dominated by that clinician sort of pull-the-body-parts-apart process, rather than you know, a whole of life. And, I guess there's no agency that really looks at whanau.

Te Puni Kokiri gave up Whanau Development this budget and said we're going to look at only successful Maori. We're going to have an elite package called Financial Literacy, and we're going to look at Rawa, and Matauranga. They're as bad as all these other agencies you know. They'll stick a little bit of kupu there and they'll say that's how we're solving the problem for Maori.

MSD is too focussed on their data, and their reducing inequality strategies, and they don't actually talk about the whanau. Health is only ever individual or personal health or large-scale meningococcal campaigns or whatever. This isn't something that they're going to put out a big neon light campaign about because it's too controversial and it has risks.

The Ministry is currently reviewing all DHB services.

We've just finished a stock take of all the services that DHBs were able to identify for us, you know the services that they do. So, at the moment what we're doing is we're going to analyse all that information, they also had some narrative stuff they had to fill out for us, find out what services are provided not only by us but by all the personal health providers as well across the country. See, the range of services identify the gaps, and then decide what we contract into from 2007. That's July 2007. It takes a long time.

Once it's finished we'd give it to the DHBs. The DHBs will have their own report for themselves that they can or cannot release on their own if they want to.

But, like I said, is that even doing this survey with the DHBs we have been doing that for eight months. Now, by the time you've developed all the letters and developed the tools and developed all that, then you send it out, then you have to give them long enough to do it, then you have to chase them up to get it in. You know, we had 100% return rate, which is unprecedented. 100% return rate. But, that doesn't mean that it was done from A or C to B, there's a lot of work that goes into it. And, then you finally get all your information in, and then people leave and you've got to find someone to do all the analysis. Yeah, so that's what we're saying. By July

next year we may be able to give a picture of what we're funding and what we want to contract, and why we want to contract those services in those areas, and why we want reorient targets. You know what I mean?

A Brief History Of The Area Sexual Health, Reproductive Health And Sexuality In New Zealand

Early history of the Ministry of Education and an analysis of Gender. Prior to 1993 there was a focus on deficit-based analysis. A job came up in Wellington, a Girls and Women's Officer in the Girls and Women's unit in the Ministry of Education. The manager there was an amazing lesbian, feminist educator who really challenged me to keep reading and keep learning as an analyst which was a bit of a different culture for the Ministry of Education. She encouraged our whole unit to build up a stronger analysis of why we were doing things that you know, the country had moved on from 'Girls Can Do Anything,' but what were the problems? And, they were new sets of problems.

Another woman joined the unit as the Maori Women's and Girls Analyst, and we started going on this conference trail. And, went to Brisbane, went to this amazing conference where for the first time I started learning about the gendered construction of identity. And, I also was doing a Masters of Education at the time. And so, I changed the focus of my thesis to look at what was the Gendered Construction of Identity in Girl's Education from '75 to '93. They were pivotal points because of the Equality of The Sexes Conference in '75 and '93 being suffrage year. So, in '93 the Girls and Women's Unit closed. I loved learning about Gendered Construction. It was a new area for New Zealand because we, the country, was still into equal opportunity, affirmative action, countering sexism, and a lot of it was really you know, reducing inequality sort of stuff. It was deficit focused, 'lets take away the barriers and girls would be great.' Well, girls were achieving but they still weren't great, and what was more, there were issues happening about boys literacy that started getting interpreted as the 'problem is there are too many female teachers and..', you know.

The development of the Health and Physical Wellbeing Curriculum

And, when they had to find jobs for us when the unit closed, I put my hand up to go into the Health and Physical Wellbeing area, which was a curriculum area which was very undermined. You know, the key ones at the time were technology, the science curriculum, the maths curriculum had all of the status, and the Health and the Arts were the last two of the seven essential learning areas that were being looked at.

So, I started looking at sexuality education within the context of the health and physical well being curriculum, and we were looking at models of Hauora, models of Whare Tapa Wha. We were trying to show that Hauora was not just an abstract term. That you could actually bring together the sports jocks and the health and home economics teachers and put them all together and there would be things in common which were about lifestyle. And, sexuality was as relevant to that as cooking, and home science, and physical education. So, at that time they were very disparate bodies; the PE teachers wouldn't talk to the Health teachers and so on. I started learning about sexuality education, and helped develop the guidelines in '93.

The persecution and marginalisation of transvestites, sex workers and people living with AIDS.

There was one queen in particular, Alexis, who also passed away and she was put into a male prison at the time. And, I remember her coming to our place. She'd been released from prison and she came up to our place and she was just traumatised by what had happened to her by going to the prison, everyone calling her a fag and a freak.

And, she was a dynamic beautiful, young, Maori queen with every sort of, everything going for her. She over dosed in the end. And, I'll always think of that dehumanising experience that she had up at Mount Vic, the prison. It ruined her life. You know, she was somebody who would, she'd be out all night and come in with these bloody stilettos, fishnet stockings and she'd come in with those and say, "Oh, darling I need a breakfast!' And, she'd make the whole house breakfast. So those years of flatting and well, you know, having lots of vibrant, amazing HIV positive people, sex workers, turning up on my door, and they used to laugh at me. I was feeling such a square.

Because, you know, learning about gendered construction of identity and the potential that everyone can be in touch with their feminine side, their masculine side, and yet the ones that were teaching me that were the queens, the sex workers, the people living with Aids who were all saying, we just want to be who we are. And, yet the people who were the health educators that would teach about health didn't want to know these ones.

There is a real lack of recognition of intersexual people and provision for intersexual needs.

One of the most challenging moments in the Sexual Health Service was meeting an intersexual person. That completely broadened my outlook on sexuality. So, this person came one day out of the blue to the clinic and, instead of going to the doctors, to the STD clinic, wanted to see the manager. Came up to me and said, "I'm an intersexual." And, I said, "Oh, hello!" I had no idea what an intersexual was, "That's nice, I'm the manager here." And, she went, "Do, you know what an intersexual is?" I said, "Not really." And she said, "Well, have you heard of a Hermaphrodite?" And, I said, "Isn't that Greek?"

Her story was incredible because had been born a girl, had both features, either an extended clitoris or a miniature penis. And, for the first year had been brought up as a girl. And then their community had all agreed that from now on her name would be Bruce. So they changed the birth certificate, the Plunket nurses ripped out the first year of her Plunket Book, and she was brought up as a young boy. No, actually it's the other way around, was brought up as a boy for the first year, and then they decided actually had more female parts. And, so became known as a girl. And, it wasn't until her mother died, and she went through all the papers, that she found this Plunket Book. And, like so for twenty, thirty years of her life grew up with this, always had a hair problem, had sort of never felt right. Went through things, had boyfriends then that didn't seem to feel right so had girlfriends, and then didn't know if she was a lesbian or whether, just had all sorts of confused pictures of the identity that she would take on. When she found this Plunket Book and realised that the name Bruce had been scrubbed out, started thinking, what was this?

And.., went to a conference in America of intersexuals, and they.., and brought back the video, showed me the video and said, "I want to do something here in New Zealand. I want to set up the Intersexual Foundation. I believe there's many hermaphrodites who have been socialised into being one gender. I want to embrace all my genders. I don't want to be known as a he or a she, I want to explore what my identity is as an intersexual."

Wanted to have a physical examination. Had never had a physical examination, wanted to have a mirror. Talked about it later as being life changing because what could have been a traumatic experience, first time had ever shown, shown the genital arrangement that characterised her body. And, the physician said that, 'That part there is, we would say, is more like a penis.' 'This part here is more connected to the uterus.' And, actually went through the body and showed the different sort of, the way that both male and female reproductive parts were connected. And, then went on and did, wanted to do a lecture and asked me to be a guest lecturer you know, to speak at the launch. I had to really accept that it was acceptable to have a sexuality that was an intersexuality, rather than a male, a female, a lesbian, a gay, a bisexual. The GLBT bracket was now a whole other category. So, I suppose my view since then, she did really influence or, he/she did influence the way that I normalised it completely for me.

There is a real lack in education of the gender construction of identity and deconstruction. So, you know, back in '95 when I left education I was so disappointed that New Zealand wasn't going to go down the pathway of talking about gender construction of identity and deconstruction, stuff that the analysts are doing over in Australia. There's a project there which was called Listening to Girls, and they talked to five hundred Australian girls about what they saw as their future aspirations, their issues. And, out of it, they realised that there were a whole lot of issues to do with identity, cross sections of identity, the multiplicity of your sexuality, your ethnicity, your class, your gender, your different abilities, they just weren't being talked about.

So, they moved into this notion of gendered identities, and I think if we had gone down that track here in New Zealand and taught gendered identities, you could then make the next step to sexualised identities. That, if you could move the majority into talking gender rather than talking sex roles and girls and boys are different, you know. That would have opened up a lot more possibilities. But, we've stuck very firmly…

Well, none of that's about gender, that's about blaming mothers, and it's about fathers have to take on more of a role of being a role model. It's very narrow constructions of a traditional male identity. It's not about exploring

masculinity. We need to do that for our Maori boys because Maori boys have got the problem as well you know? They're not reading, and Maori boys are the lowest of the low, and I thought, 'Goh!' It's bad enough that Pakeha boys are doing it but to then throw into the whole, the context of whanau, to separate out the boys from the girls. To say the boys are the problem, we need to fix them up, and to say that girls are fine.

The responses of Maori girls to sex have been learnt.

I mean there are a whole lot of arguments about, 'if girls were fine why are they getting chlamydia?' Because they've been, you know, they've been socialised into being good and cooperative and pleasing and so they won't insist on having a condom, or asking their partner to have a sexual health test.

At the sexual health clinic we used to talk about a sexual warrant of fitness. Before you enter into a relationship, when you are at your most lustful, loving, you know, at the very point of starting a relationship you should say, 'Look, I really want to but show me your sexual warrant of fitness first.' And it was a neat idea. Nobody went for it but it is that thing that you know, you need to know who you're sleeping with, who your partner was sleeping with before they were sleeping with you.

Public Health Contracts & Public Health Campaigns

Public Health funds a variety of contracts, such as health promotion, campaigns, and data collection.

Public Health contracts include a bit of health promotion in schools, such as running programmes in schools around sexual and reproductive health that encourage safer sex practices. Campaigns that you see, such as promoting the use of condoms, are the sorts of things that are funded through Public Health. We (Public Health) did the Hubba Hubba campaign, the national stuff.

Public Health also funds all the ESR's data collection on STI's. In some locations you have health promoters that will work with different groups, like with Maori. Other Maori providers look at how they can deliver programmes and work schemes, and those other things about safer sex. We fund a lot of the health promotion campaigns you have through Family Planning and the New Zealand Aids Foundation. They're all funded through us.

Only 2% of the overall health vote is public health.

Only 2% of the overall health vote is public health. Then sexual and reproductive health is a very small part of public health.

Yeah, so the DHBs get all the funding and they distribute it to the PHOs and everybody else.
Public Health funds contracts where people are employed full time in sexual and reproductive health. They don't fund integrated contracts as yet. Most Maori health workers work widely.
Providers are required to report back to the Ministry on the services they provide and any emerging issues.
Every Maori sexual and reproductive health provider we have is required to report to us on the services they do, any emerging issues that they have. Some of them are asked to report back on any projects that they're implementing and they've got to evaluate those and report back. So, we can get information back from individual organisations.

Ministry priorities are largely determined by the statistics. These priorities then determine the campaigns that are funded and implemented.

The gonorrhea rates are increasing as well as the chlamydia rates. HIV rates are increasing and Maori populations are particularly. I mean we have such high STI rates, and that's possibly because we practice a lot more unsafe sex, and where you practice unsafe sex is where HIV has a pathway through. So, it's not that I think that we're any more promiscuous it's more about the practices that we have. I talk to a lot of young people too and a lot of them don't want to wear condoms, they don't think it feels as good, and you think to yourself, 'Well have you tried it with a condom? Have you tried it? How do you know it doesn't feel as good?' You know? That kind of thing. So, I think that we are particularly vulnerable to it, and the Pacific peoples have huge rates now too.

Public Health decides what are the key themes for each area, what are the priority areas of health in sexual and reproductive health, based on identifying 'crisis' areas.

> *Public Health makes calls on what is achieveable with the small amount of funding. So they are campaigns focused and assess where the crisis appears to be in order to make decisions about priorities e.g high rates of chlamydia equal a campaign. Advertising agencies are used for public campaigns.*
>
> *Public Health identifies the priority areas, which are based on statistics usually. At the moment chlamydia is a big issue. If we were going to run a campaign, and we were going to run it on an STI, we'd probably pick chlamydia for that reason. And then we'd say, 'Well, we've got chlamydia." So, if we break that down, which are the biggest groups? Then we buy in an advertising company. And, then it's their job to bring in the groups of people; it's their job to talk to them. You know, that's what they do, its not what we do. We just tell them they have to.*

Planning a campaign requires focusing on a key area or message, coming up with a quick catch-phrase, and identifying the target audience.

> *If we want to plan issues, if we want to plan an approach that we may want to take, we will develop a campaign. So, with the Hubba Hubba campaign we decided that promoting condoms would be our key thing. We decided we would talk to all the providers that we contract and say, the key thing is the use of condoms, and we want you to line up these services and all your promotions around that as well so that we've got an across-the-sector approach to the key thing.*
> *You can do all sorts of things. However, if you want to use something that goes across all areas it really does need to be a major campaign. And what we know about campaigns is that you need just a quick catch-phrase. So, 'No rubber, No hubba hubba' is a quick little phrase, which is easier than, 'If you're in a relationship you have to treat people really well.' You know?*
>
> *Most evidence shows that the use of condoms does reduce STIs. Although condoms can break, it doesn't happen often. If it does happen it's because you're not using it with lube. You know what I mean? So, it's a message that we've got evidence about as well.*
>
> *And then, we think about what the target audiences will be. For us it's youth because that's where the highest rates of STIs are, in youth. And, then we think about who had the highest rates out of the youth population, and they were Maori and Pacific. And so then, what we did was we worked out all those things and then got groups of young people in to talk to them about what they'd want, what they see, what they'd listen to.*
>
> *We get messages about sexual and reproductive health from all variety of sources, such as the media. However, they may not be the messages that are appropriate.*
> *Yeah, you get the messages in media, in films.., in Bridget Jones Diary you know, just thinking of those.., Four Weddings and a Funeral. What you're seeing is a blueprint of how people should be.*
> *Though health messages? Ummm…*

However, interventions by and for Maori are more cognisant of the complexity of rangatahi behaviour and the impacts on whanau.

> *Using youth suicide as an example, the Youth Suicide Strategy. We developed Te Piki te Ora with Te Tai Tamariki as a holistic strategy. We had as our focus the whanau.*
> *The Ministry of Health talked about suicide in our hands was their strategy, and they placed the adolescent at the centre. We had the whanau at the centre, and ours was more conceptual so they sort of had adolescent, parents, school teachers, community. We had things like whanau development, cultural revival, information, education, different sorts of research, and different ways of talking about it.*
>
> *And, I think the two worlds couldn't operate together. They kept saying to us, 'but you need to start talking about the Maori boys having such a high rate of suicide.' We're saying, 'if we do that we forget that Maori girls have the highest rate of attempted suicide. But what you're saying here is that just because you attempted and failed, you girls can't even kill yourself, that it's not worth it. You're only talking about the success stories. You know, that's the one you're giving the status to.'*

And, we were saying, 'it's not just about the young girl and the young boy, because it's about the cousin that watches that and is influenced by it, and has a model. The mother that never forgets it, the Aunty that won't talk about it.' There's a whole network, that you can't take one out from the other. It has trauma for the rest of that whanau's life.

Training For Providers

There are limited training opportunities for Providers.

Family planning of course offers their training to anybody to attend if they want to. Depending on what your role is, if you're a nurse you've had nursing training anyway, do you know what I mean? And, that you should have the ability to do those sorts of things with people regardless of who or where they come from.

Career pathways in sexual and reproductive health are also limited.

In terms of a career pathway for sexual and reproductive health for Maori, there isn't really one for anybody let alone there being one for Maori. As I say, Family Planning runs some courses but there is no career pathway working through sexual and reproductive health per se. Let alone that there is one for Maori.

And, if you talk to any other NGOs they will say it's extremely difficult to recruit people to work in sexual and reproductive health external to any other nursing role you can get in the hospital now that they pay so much money. So, who knows, I mean even the doctors are screaming out and saying they've got no registrars coming through specialising in sexual and reproductive health. And you know generally speaking for people who aren't doctors there isn't a pathway. For a doctor there is a pathway. You could be a registrar but no one wants to do it, you know?

There is no funding for capacity building to deliver more confidently on kaupapa Maori sexual and reproductive health.

I need to be honest I don't actually have the korero, the know-how.., I think.., I mean, a little bit but not what I'd like to have in terms of what that means to be able to work in a kaupapa Maori way. But, I'm assuming that they [the Ministry] think I do so whatever we negotiated, signed off on in our contracts is taking into account the Maori perspective. But, I don't feel it does, I mean that's not there, I don't see it there.

Te Puawai Tapu As Key Maori Provider

Te Puawai Tapu was the first kaupapa Maori sexual and reproductive health provider and had a particular history that is important to the development of the area generally. Te Puawai Tapu have used different models according to the political times – starts off as taha Maori type development within Family Planning and then goes independent.

I remember the struggles that Irihapeti Ramsden, Pania Ellison and Papaarangi Reid had in establishing Te Puawai Tapu. And then more than 10 years later we all brought Te Puawai Tapu out from the New Zealand Family Planning Association (FPANZ). They had set up the organisation inside FPANZ because they were following Irihapeti Ramsden's model of parallel development…At that time the links between the organisations were at both governance and an organisational level. At the governance level, both organisations shared governing members across their organisations. So TPT provided two people through to the Executive Council of FPANZ and FPA provided two people to Te Puawai Tapu Executive Committee.

The Executive Committee of TPT at the time felt that they wanted to cease that intermingling of Board members, they felt that was something that came out of a previous model and a previous way of thinking for both organisations, and they no longer wanted to pursue that.

So a trust was set up, the trust was incorporated, and with that trust came the TPT Board. They also moved away from the incorporated society model because it was expensive to maintain the Executive Committee, the members of whom came from around the country. So it wasn't just about moving away from FPANZ, there were also some cost considerations. I think the TPT trust was set up at the end of 2002.

I think it would be safe to say that FPANZ would've preferred to stay in a situation where the two boards were intermingled, but certainly for TPT and for the people who then became the trust board members, it was really where they wanted to be, they wanted to be a separate entity.

TPT had a contract for services for sexual and reproductive health services with the Ministry of Health. Within the Ministry of Health contract there were two arms; there was service delivery to schools, and then there was policy and advocacy. And then there was the HRC [Health Research Council] research contract, and TPT was the first organisation outside of a university to hold a big HRC contract.

Te Puawai Tapu has had MOH funding since 1997.
Te Puawai Tapu has had MOH funding since 1997. We funded the very first proposal that came through to do this sort of work. They didn't exist before that, they were Family Planning. So, we've seen the development of the services and the development of the programme, which is the year 9 and 10 programme, which is what we fund. That programme was evaluated. The programme is based on Kirby's, he's that guru from the US and he talks about the content of programmes that you have for young people and what they should have, what they should build on. Yeah, he says it shouldn't be just about sexual health, it should be about communication and relationships, and all those other sorts of things. And, sex should be something that's part of it but not the core thing. And, the year 9 and 10 programme that has been developed by Te Puawai Tapu does that. It does have all of those sorts of elements.

We would love to see that programme implemented at higher rates all over the country however, the school environment has changed now and there are all these other types of things and we can't dictate to schools what they should and shouldn't have. Kirby says it's a programme that should be over a minimum of eight sessions, you know the programme that Te Puawai Tapu has is a ten session thing. Well, now they've had to moderate it and sometimes they have to do it in four or six or eight. Yet, the whole programme is what's successful.

Te Puawai Tapu were consulted about the Sexual and Reproductive Health Resource Book
The Resource Book and that, they were written with Te Puawai Tapu as well. You know, a group of people who wrote that. So, there are some Maori action points in that.

Securing and maintaining funding for Te Puawai Tapu was difficult for previous staff. At different periods during the life of TPT the Ministry was hostile.
A previous contracting group in the Ministry had been very hostile to TPT…The Ministry was hostile to Maori providers in general, and in that sense TPT had a hard time. On top of that, the sexual and reproductive health sector is minute, and sexual and reproductive health is not one of the top health priorities for the ministry. So I think that that compounded the problem…

The Ministry could not see the extent of the problems in sexual and reproductive health for Maori. I think that was part of the hostility…

The way forward was to build relationships with the Ministry, work closely with them, but also build much stronger relationships with the Maori sector, and to try and channel the voices of other Maori providers into the Ministry, so that TPT wasn't a lone voice. For that reason we held the first-ever National Maori Sexual and Reproductive Health Conference 2004 (Takapau Whariki – Horahia Mai), but we'd done quite a lot of legwork before the Conference in terms of building our relationships with other Maori working in the sector.

The priority for Te Puawai Tapu was Maori and identifying, building and strengthening the Maori sexual and reproductive health sector.
And for me the priority was Maori; it's not necessarily what other Managers would've done, but for me our strength and our ability to start to make in-roads on the statistics, sexual and reproductive health statistics, was to build Maori capacity. So we had to build our own but I believe that we had a lot to learn from other Maori providers, and vice versa… we did a lot of knowledge transfer.

So we had the Conference, and for the first time we found out how many Maori were working in sexual and reproductive health. In the lead up to the Conference we did a survey with the support of the Ministry, to try and find out how many Maori were being funded in sexual and reproductive health. Before we did the survey, the Ministry didn't know.
What we found was that most Maori organisations delivering sexual and reproductive health services and employing Maori staff to deliver sexual and reproductive health services are doing this work using mainstream contracts. We found out that in the beginning of 2004 there were 25.5 FTE Maori working in sexual and reproductive health, most were working with Maori clients, but not all. Some providers had Maori staff but the Maori staff had no ability to work just with Maori. They were meant to be working with everybody.

So we found all of this information out, and we used that information to give Maori working in the sector some important knowledge about themselves, about what they're doing, about how they are being funded relative to the non-Maori sector. We used the information as a basis to start lobbying on behalf of the other Maori providers to increase funding into the sector. That first conference that was held, it was wonderful…

Building policy advice capacity in TPT and the change in Ministry policy.
When I joined the organisation, the way that the policy and advocacy part of TPT was running, it was a joint policy and advocacy contract. The Ministry moved away from the 'a' word, advocacy, after the big scrap around the smoke-free coalition, but in 2002 and the word 'advocacy' was ok. But when I joined the organisation, the policy and advocacy services were centered on TPT identifying what the policy priorities were, and TPT developing papers and responses to issues in the sector.

When I joined TPT there was a link with FPANZ at the governing level, but also a link at the operational level; in fact the policy person for TPT was also the policy person for FPANZ. And there were protocols around how to provide policy advice, and these protocols were agreed to by both organisations.

That didn't sit well with me. And so when TPT separated its governance from FPA's, it wasn't long after that, with the support of the Board, I separated the policy and advocacy services. We grew our own policy contract, we doubled it and then I changed the focus from being about what TPT wanted, to using the national working group that we'd pulled together to organise the Conference, to also identify sector-wide priorities for policy and advocacy. Our job was to craft the papers or the responses or organise deputations to the Ministry or to whomever, that was, our job was to do the legwork so that the policy advice we provided was much more of a sector response. And so part of the funding that we used to run the Conference was funding that had come to us under the policy and advocacy contract because in running the Conference we were able to provide policy if you like, in its most general sense, policy advice to the Ministry in terms of the papers that were being delivered, and the recommendations from the Conference, and the report from the Conference.

Te Puawai Tapu becomes too strong for the Ministry with its focus on Maori needs
I don't actually know that this is a fact, but I have a sense that TPT became too strong for the Ministry and our strength came from our ability to work in the Maori sector, and pull people together to provide a strong and united voice. We organised, we wrote to the Ministry, we asked for meetings that brought together people on particular issues, and we had some funds that we were happy to use to bring people together from around the country.

Once the conference had finished the national working group finished but we wanted to continue it to ensure that that policy and other work we were doing was representing the Maori sector. I have a sense that we got too strong, frankly, and that it had suited the Ministry better to have disparate Maori voices. Call me a cynic!

There was incomplete sexual health data for Maori and the Maori sexual and reproductive health sector. We lobbied the Ministry and the Minister for better data collection with little result.
When I took on the job it was made clear to me that one of the key issues for us was not having any sexual health data. So we began lobbying the Ministry to try and get statistics, some comprehensive statistics, and we found out that they don't exist. But we were saying, how can the Ministry monitor disparities between Maori and non-Maori in sexual and reproductive health if we haven't got accurate and comprehensive data? As a Maori sector, we wanted to be able to plan and monitor the impact of our work on the sector but to be able to do that we needed to have comprehensive and accurate data. And such data doesn't exist. The ESR collect and collate the sexual health data. But there are holes in the collection process. For example, the GP data isn't included into the ESR data. The laboratories do provide their data to ESR, but much of that data is minus ethnicity information. The sexual health clinics (i.e. DHB clinics), and family planning clinics, and some school health clinics (these are family planning funded clinics that operate in schools), provide data to ESR, but all with ethnicity information of variable quality. So we've got apples and bananas, you know. TPT was writing to the Ministry about this issue, writing to the Minister about this issue, wanting to meet with the Ministry about the state of the FTE's for Maori, asking questions about the efficacy of the million-plus dollar sexual health campaign 'no rubba no hubba.' I don't think we made friends in high places…

Te Puawai Tapu's role was seen as lobbying the Ministry on behalf of the Maori sector
We saw it as our role, on behalf of the Maori sector, to work with the sector to bring those issues to the attention of the Ministry. When we couldn't get any response from the Ministry, then my Board made the decision to write to the Minister, Hon. Annette King. We continued to have the friends, but we had difficulties influencing people in senior positions! I think we were seen as a threat…

Kaupapa Maori means working in partnership with the Maori sector and the mainstream organisations
I think it's the way the contracting has been devised too. There certainly was strain between us, between TPT as a Kaupapa Maori provider, which meant working in partnership with our Maori sector, and the mainstream sexual and reproductive health services, and I'm talking primarily FPANZ.

Distinct Barriers For Maori Providers

A good relationship with the Ministry is seen to be essential for ensuring funding.
Another thing is that we have a good relationship with the Ministry, and I think they actually do allow us to do what we can in our way. I think they allow, I think we have a good relationship and it's been happening since 1999. And, yeah. I think it's good.

The Ministry workers change over time but they are advised by the outgoing workers.
I think what happens is that the people that come on actually get an induction. I haven't had to do the whole induction thing too much with the new workers at the Ministry.

Just translating existing programmes into Maori was criticised by those delivering health and education services.
That in itself is you know, fine but, the Ministry of Health.., part of their resources is they use Maori kupu to.., like when talking about body parts. And so kids pick up on this because it's a different language. But because it's a different language they use the language inappropriately. So, that impacts on the self-esteem of Maori kids. And, so you know they don't tend to want to contribute in the classroom when a programme like sexual education is being delivered.

The Ministry controls the contracts that Providers deliver. Providers can see these controls as constraints put on contracts. The Ministry however wants to control the focus of delivery in line with their strategic directions.
The Ministry of Health control those services that we're able to provide because they have their agenda of who they think is a priority area.

With the Ministry, they focus on services that address behaviours rather than services. This helps to change attitudes because that's kind of the part of us that is sacrosanct. 'I don't want to change unless I want to change.' So, it's better to tell me just to use a condom without maybe going into some of my attitudes about why I may, or may not, choose to use a condom. So, that's why people or some services get into the, 'let's show the extreme bad affects if you don't use this.' The scare tactics.

Early campaigns were based around the scare tactics.

Providers see that there is a need to be more explicit around sexuality as a separate discussion from sexual and reproductive health.
The Ministry do tend to focus more on the sexual and reproductive health, and sexuality is implicit in that. But, actually it should be more explicit but then they wouldn't fund that. So, what we're trying to do is do the best with what we've got. So, we're trying to put sexuality to the forefront, even though we're funded for sexual and reproductive health. Or, the terms will be used 'sexual and reproductive health' including 'society' and 'culture' and 'personal skills,' and all that kind of thing. But really what they should be talking about is sexuality.

Providers need to be involved in setting the priority areas for sexual and reproductive health funding and contracts. Contracts also need to be more cognizant of whanau, hapu and iwi.
The problem is that we are always operating off crisis or responding to contracts rather than doing the planning and the groundwork. Why haven't they developed contracts with whanau, hapu and iwi? The Ministry's funding is all around youth and urban populations. This needs some re-arguing.
So the MOH I think have their own relationship in terms of where they want to go. And I don't think they're necessarily sensitive to our needs as Maori providers. I think a lot of it is tick the box stuff.

Sexual and reproductive health service is totally defined for Maori. The way that the Ministry defines the sector is different from how Maori would consider health and wellbeing.
It's totally defined, unfortunately for us as Maori, by two things. First of all by the Ministry's contracts because it's impossible for Maori providers to find alternative funding streams or at least funding streams that are constant, that you can build a service

around, as opposed to the short term, small amounts that TPT was cribbing together before 2002. So I think that's the first thing, the Ministry's health contracts have defined the services that we providers provide.
The other thing which, again unfortunately defines sexual and reproductive health is, if we've got some statistics, if we can count it, then it must exist. So the focus becomes STI's and pregnancies and abortions and contraceptives. But in an ideal world I don't think that's how Maori would define sexual and reproductive health. And that became clear at the Conference. There was all the usual things being talked about like STI's and condoms, but then there was also a lot of talk about areas of wellbeing that the Ministry wouldn't define as sexual health. And we're talking the wellbeing of whakapapa, and knowing our whakapapa, and knowing how our ancestors might have experienced sexuality. And I have a sense that Maori would find it very hard to pigeon-hole this 'thing' that we now call sexual and reproductive health. There are some areas which are more obviously, which we might go, 'yes that is,' but that would be because we have become used to seeing those things as sexual and reproductive health. So I'm talking here, reproductive health, conception, contraception, STIs and HIV/AIDS.

The difficulty of working with mainstream providers and the exacerbated difficulties for rural as opposed to urban Maori providers.
FPANZ are very, very powerful and they have got friends in high places. We didn't. I think people in mainstream organisations have mainstream or non-Maori people as their priority. In that sort of scenario we are only ever a small voice and we get totally marginalised. And you know, we are always ringing the bell, and it doesn't work. For small Maori providers in rural areas where support is hard to find, they don't have a lot of choice in terms of who they work with. In a city, and in an organisation our size and with our funding at that time, we had some choices. The other Maori organisations didn't. And so they were walking a really, really difficult line and they were put into that position of trying to walk that line, and they were giving it their best, but the price was high. And they knew it, the Maori organisations knew it. It wasn't that they were blind to it, they absolutely knew what the cost was – the huge trade-offs...

The sexual and reproductive health workers don't even work together regionally in some areas.
That's what I would see the rationale for having these regional collectives, yeah.

The Ministry and mainstream organisations shape their contracts and services on individual, as opposed to whanau, rights. This has implications for Maori.
From my time kicking around the offices of FPANZ and other mainstream organisations that provide clinical services, that whole issue of the rights of the individual really shapes the way they run their whole services.

The Ministry contracts also reflect the same issue; the rights of the individual. They don't contract for any 'whanau' services. We met with the Ministry because we wanted to trial a different kind of clinical service; a whanau-focused service, and the example we gave was say a whanau find out they have a son or daughter who is in a situation where they need some sort of clinical intervention for something, and the family, lets say in this situation the family is the primary support, the family wants information in order to support the person to make a decision. Two things happen.
First of all, FPANZ doctors won't meet with family members; instead they will only provide clinical interventions to the identified client (in this case, the son or daughter) and sometimes, if the identified client pushes the doctor, they will agree to a parent joining the consultation, but really only as an observer. FPANZ say they are not funded to meet with the family, only with the identified client, and the family can't be an identified client. But I'm not sure that this is the only reason; there is the issue of the primacy of the individuals' rights, as opposed to the rights of the entire whanau. So that's the way the Ministry contract sexual health services in general.

Te Puawai Tapu was part of a PHO and that PHO was happy to trial a sexual and reproductive health service for rangatahi that was actually for whanau. The proposed model would not suit all whanau or all rangatahi; the affects of colonisation are so deep that many rangatahi believe in the Western way of thinking about the primacy of the rights of individuals. But for whanau who suited a whanau model, the whole family could come along and meet with a doctor, and get information in order to make a family-based decision, or support the family member to make a decision and support them in the follow-up. So that's why we went to the ministry and they were like 'No, no way.'
Again I think we were pushing the boundaries; the fact that we were wanting to test out that track, the ability to fund a service that tried to get away from just individual rights and instead wanted to address multiple rights, group rights, the rights of whanau, hapu and iwi.

Maori think about things much wider, including whanau wellbeing, hapu and tribal wellbeing, and whakapapa.
But I'm also sure that as Maori we would think about things much wider…we would include whanau wellbeing, hapu and tribal wellbeing and of course, whakapapa. That's why it's neat to have research projects to try and get a sense of really what our

communities actually think, and want. And it might not be even a label, sexual and reproductive health. It might be something much more general. The phrase 'sexual and reproductive health' is medical and very western and it's the effects of, well two things, we're using the colonisers words, and we've been colonised to think of sexual and reproductive health as things that happen in the private domain, not something like whakapapa which is very much in the public domain! You know, we wouldn't sit at a café and talk sexual and reproductive health without people thinking this is really inappropriate, you know. Victorian attitudes of the coloniser mean that sexual and reproductive health matters get boxed up in a way that I don't think is healthy for us. I don't think it reflects where we've come from as a people, but I don't think it reflects where we need to go in terms of Maori sexual and reproductive health and wellbeing…

It is important to be aware of the issues around individual rights and whanau rights.
Say in the area of abortion, where does the argument of whanau rights fit as opposed to the individual life that's been formed? And Aunty always talks about having a Kuia that used to come, that was part of Te Oranganui [Hauora Provider], that they always wanted to have a Kuia on board so that when a young woman walked into the service with a partner or with whoever, and said 'I want to be having an abortion,' instead of what the legislation says, that there must be some counselling or informed consent, you must talk to the health practitioner.
And, she'd always said, but you must also have a Kuia there who can say, there are other people to consider here. Is this the only choice you've got?

And, so I guess in terms of the work that I'm doing now, we are very much focused on when you conceive you're not talking that individual problem. And, that got us into some hot spots about the concept of teenage pregnancy because, we have said consistently that conception is a miracle, that the treasure of life is upper most. And, that the carrier of that life is not necessarily the only person to be considered.

There is a strong argument that sexual and reproductive health is the role of the whole whanau; it can't be separated, individualised or negated.
The system has individualised health, so it's the Kahui mother or father, the King father, are the two people involved and that's it. Whereas, what we were saying is 'No, the whanau is always bigger than the one.' It's not just the boys mother or father that are at fault, or the stepfather, or you know whatever. There is always somebody else. There's nannies, there's aunties, there's somebody that you can go to. And that's what we thought of with teenage pregnancy. If the difficulty was with the woman, the young woman not completing her education, she can complete her education but the baby can still be loved and treasured as another precious member of that whanau. And, so that question about individual versus whanau rights, I think is really at the key of sexual and reproductive health. That is, if you're not discussing the issue of say, HIV/AIDS amongst the whanau, or you're not discussing the issue of chlamydia amongst your young women, then you're effectively, you're complicit in allowing the population to decline. You see, it's about whanau also taking responsibility to question sexual practice.

We need to move away from thinking of controlling Maori fertility and sexual behaviour – it has always been problematised.
I know with one of our children, she's whangai, maybe sixth or seventh child of ten children. And, each of those ten children has been taken into care through CYPFs. Now, some of the statements that people in the system, CYPFs and social workers but also members of the whanau, have said about her birth mother is, 'you know, isn't there something that can be done to stop her having children?' Now, the problem with her, the situation is not her ability to conceive and to give children and to carry the miracle of life, the difficulty is that she hasn't had the support. Her parents didn't have the support. Perhaps they weren't in the space to also call out for that support. They didn't see it as a problem for themselves. So they are problematised and you know, their children are taken off them. Statements are made about her, her reproductiveness. You know, it's that same sort of natives breeding thing again. And, that becomes the problem rather than you know, they're also part of the whanau. There could have been perhaps more energy put into supporting them to be effective parents instead of just removing the problem and saying that 'she should have a hysterectomy,' you know, 'we must do something to stop her doing that.'

Teen pregnancy should not be stigmatised but rather be looked on as an issue of who is available?
I attended a meeting with Ministers and they were saying there's a huge problem in New Zealand about Maori teenage pregnancy, and I asked the question, is it really a problem? And, they were very concerned with my arrogance to ask a question. He was the Education Minister and she was the Health Minister. Firstly I was out of turn for daring to speak when Ministers were having a conversation. Minister of Youth Affairs and they're all sitting around discussing the Maori teenage pregnancy problem. Now, there were no Maori officials in the room, there was nobody there from Te Puni Kokiri, from the Ministers department. We subsequently talked to Te Puawai Tapu and we talked to Ministry of Health and said, 'we're not saying that having a teenage pregnancy isn't difficult but, we are saying there are ways that you can look at it rather than a

problem. Rather than stigmatising it, if you look at who is available.' And, in many ways it's the same as the way that they've conceptualised problems to do with CYPFs, child abuse, child dysfunction.

For young parents we don't want them to feel they are wrong or different, but we also don't want to normalise it.
It's interesting because there are some young kids at kura that have had a child. Fifteen, fourteen I think, and so they're very much part of the kids talk as being what happened to these two parents and they've got this baby. And part of me has thought about that. For the sake of the young parents you don't want it to be seen that there's anything wrong or different in their behaviour. But, you also don't want the sheer visibility of the pregnancy and the birth and the child, you don't also want to normalise it so it becomes too much of an option, or too easy an option.
We were just talking about the young mum this morning, going back to kura next year to continue her education. She had been going to that young teen mother school but clearly there's something that's not being offered, which means she's coming back to kura. I think this is a really positive thing, an obvious sign for the kura you know, they're accepting a young mum back and that she feels good about coming back.

Sexual behaviour is often monitored and controlled externally when problematised.
Using sexual behaviour as the control, where sexuality of special needs children, or residents with intellectual disability, or physical disability has been seen as the problem in a situation.

I remember one mother ringing and saying my boy is constantly masturbating. I had in the back of my mind, 'So? Masturbation is great.' And, the mother was saying this is a huge problem. I've taken him to Maori social service providers and they're doing nothing for him. Now, as Maori we don't allow that sort of thing. She said, as Maori we believe in respect, and we believe in, you know.
So she was basically saying not only was his sexuality a problem, his sexual behaviour is a problem, but that it was an un-Maori thing to do. So, he was un-Maori to masturbate. His masturbation, to her, was something that should be disciplined. She felt that the social service, the Maori social service provider she was going to in Auckland who was a disability provider, was turning a blind eye to it. And, the mother said, 'there are young women in that home, and he's there and he's masturbating in his room.' I mean, she saw it as a criminal act, and that he should be told to stop it. She wanted, you know, the Associate Minister of Maori Affairs to write to the Maori provider to get their contract pulled. Her thing was that one day he's masturbating, next thing he'll have raped someone.

Sexual and reproductive health is not separate from the spiritual dimension.
Yeah, so what needs to be done about Maori sexual and reproductive health? I think although we put lots of energy into talking about the miracle of life and the miracle of conception, and the notion of holistic health, there needs to be an understanding that you can't distance the spiritual dimension away, you know? Like when I was talking about conception, I absolutely believe that behind my girls birth was the spiritual dimension. And, you know, the nurse who talked to me about the physical thing. She gave one bit of information, but our social environment was fine, our emotional readiness was perfect.

KAUPAPA MAORI SEXUAL AND REPRODUCTIVE HEALTH

PART FOUR

Kaupapa Maori – Korero Mua

This section pulls together interviews/writings that give an introduction to the depth and breadth of hapu and iwi knowledge that exists when Maori sexual and reproductive health is talked about. What is the traditional knowledge of Maori about sexual and reproductive health? While the speakers/writers discuss this issue, they also say that it is important to be critical of the way that we have been told traditional stories. This area of traditional knowledge is an area that many of the interviewees felt was lacking in their work but which they did not feel qualified to get to grips with. Each of the speakers raises points that contribute to the ongoing korero that exists in different rohe. They also ask critical questions and talk about further discussion and research that needs to happen in this area.

This interview was important for showing how whanau shape and change attitudes to sexual and reproductive health.

He Kaikorero No Nga Rauru

We actually started in wananga at about 4, when I was about 4. That's when we were taught about what we needed to do, where we could go and all these other sorts of things and we were actually taught through the experiences of our tuakana. So we have a part on the beach back in Nga Rauru called Waikaremihi and at that time we weren't allowed to go to the beach. Well actually not so much us but the older ones weren't allowed to swim, they weren't allowed on the sand if they had their mate and it was at that time they started to explain. Well you cant because it turns the tide, it turns the sand and the sand turns the sea and the sea turns the fish and we cant catch anything. If you had your mate you weren't allowed on the beach at all so there were a lot of those sorts of things and there was also the stuff and now when I look back we are related to Rona and the moon. That is the easiest way to explain the mate. But there were also different things about the use of moss and to catch the flow and those sorts of things although I understand that on the coastal areas there was a type of sponge that was used to absorb the flow. All those sorts of things so I think I started as a child and then we weren't allowed to cut our hair because of the energy flow and the protection of the matauranga and those sorts of things. I think that in terms of learning about sexuality it began at home. I learnt about relationships at home. And so the relationship of my grandparents to us and the relationships and importance of whanau because sexuality if it is defined culturally then it underpins everything that defines my relationship with my parents, my mokopunas and all that.

Karanga

It's that basic learning influenced us when we were taught to karanga. So what it was the use of moss in the houses as aitua and the teachings and getting lazy and leaning up against the whare and you'd get taken. And I think it was more out of fear that you didn't do it rather than the actual understanding of being taken. And so there was a lot of that learning, it was about the diligence but I think that it also impressed upon us the commitment to learning something but learning it well. Because we do write lots of things we have this habit of oh well I'll read it later whereas when you sit in the dark and you are bombarded with the information, you wake with it, you sleep with it and they are things that stay for a very very long time and so in learning about sexuality and learning around whanaungatanga, whakapapa that as I've become older and I've started to have my children, you think when you get your mate, you've reached that puberty stage and its finished but its not. Its not until after you've graduated into kuikuitanga so you've actually gone through that whole cycle. So in terms of wananga it's a whole process because of those concepts. Those concepts of sexuality actually determine why you stand on the marae, the place you stand, souring the kai, going for watercress. I have a cousin that is quite sour and she is not allowed to touch the watercress and she's always like that when she has her mate. When anyone has their mate they are not allowed in the freezers, various places and it's become more of a way of life.

The Reproductive Cycle, Burying The Whenua And Mokopuna

In terms of the reproductive cycle having children the way we do, we've become very casual in our approach to it whereas there was a formal approach and I think my grandmother delivered it to my mother and from my mother it came through to us and to me and my children and my mokopunas. They always say that you never know how you've done as a parent until your mokopunas are displaying the values that you taught your own children. So that's some of the philosophys that have kept us safe. Lets put it this way I use what works well until it doesn't prove useful anymore and I'm close to a lovely age at the moment. And its kept me safe right up till then and its kept the birth of my mokopunas safe and it's things like doing the karanga, burying the whenua, all those sorts of things.

Whanau

When my last two mokopuna were born we had a koroua, it was actually my great grandfathers brother and he got wounded. He went to the first world war, came back and he never had any children so what we did, we developed a relationship with him and we developed a relationship in this way, we said to him we will always remember him. He has died now and we remember him by burying the whenua by him so he will look after these mokopuna. And so that's what we do, so this mokopuna has become their koroua. And that's part of the reproductive and sexuality side of it that we don't necessarily consider important but it is in terms of spirituality and if that umbrellas all that we do, it must influence who we become. So the mokopuna, ones one and ones two and now when we go out to the marae they call him Koko Moe because he's asleep. So when we went out there we went through the process of burying the whenua and doing the karanga and karakia and the exchange and it became part of their learning about sexuality. So we all went as a whanau. While the moko and the mummy didn't come into the urupaa because it wasn't their place to come in. It was our place to go and do that. It became really touching for all of them so that's become a really strong part of all their learning in terms of their sexuality.

Sexuality As Taputapu

Learning about sexuality is life long and I think that we quite often talk about taputapu and the area of sexuality as taputapu. Well I believe that's a load of crock. I remember a waiata that was done. It was done by the old people and we have jazzed it up a little but it talks about the relationships, the sexual relationships between partners. It talks about how one would entice another and it was used especially after a tangihanga after the whakaputa which is the movement from the dark to the light and this was moved to bring the pouaru (the widow) or the bereaved family into Being, back into Te Ao Marama, ki te Whaiao, ki Te Ao Marama and it was used to encourage them to start living again. So it was not only a spiritual movement from dark to the world of light but it was also a physical movement. These were some of the waiata that we used. I personally believed that the taputapu part of sexuality existed around the act of intercourse because of the implications it had on whakapapa and if we talk about degrees of tapu, that in itself becomes tapu because the implications on whakapapa become greater, whereas sexuality is the environment in which it survives. So it's really interesting and I think that now is a time for restoration of Maori thinking. We've had the revitalisation of the reo so I'm pretty sure that the restoration of Maori thinking has gotta come next because we wouldn't treat ourselves so badly.

The Importance Of Whanau

We attended a hui a few weeks ago here in Wellington and it was a Maori caucus hui. One of the kuia came along and her comments that she made around gay relationships were shocking. Whanau had no place in there. It was terrible. In actual fact I think people actually wanted to walk out. So from our point of view, that's not whanau, because whanau is whanau regardless. And I suppose in our own family, we have generations. I mean my Mum, her sister was in a same-gender relationship. And when we talk about the term takataapui, I'd never heard it before because it was whanau. It didn't matter that, I mean you didn't go 'well, I'm straight' or 'I'm gay.' It was 'hey, I'm whanau.' That was the pinnacle of your whakapapa, where you belonged. And so I think from the age, I think when my aunty was in her relationship I was about 10, and we call her Nanny. All the kids and mokopuna's call her Nanny. And they call her and her partner, Nanny and Koko. And that wasn't to show genderism but it was to show that they were in a relationship, in a partnership. It was more about whanau. And I think we tend to identify ourselves as individuals rather than as whanau. It's never been an issue in our whanau. And that's probably because both my parents were brought up under the influence of strong families. Family was the most important thing. In fact before my father died he made us promise that we would spend one weekend out of the year together, just to be together as siblings. And we still do that and he's been gone close to 30 years. So if we can't be together at Xmas, we'll have like a pre-Xmas. And so it's just to be together, and we actually find that we appreciate one another more because we don't feel obligated to be there. It's about being there, enjoying each others company and then leaving. So I think because our parents had strong whanau understandings it's influenced where we've gone. So all my relationships, all my understandings around sexuality, around reproductive health have all been growing up as a child by my parents, the influence of our grandparents and our great grandparents, and some of the teachings. And I think without that, I probably wouldn't be as confident as I am in terms of who I am as a Maori woman.

Aitua

For me he tohu tera. It's a tohu. It's only a sign. What we do with it makes the difference. To give an example miscarriages or kahukahu aitua. The unripened seed. And so it's not yet completed. Some call it an omen. But for us we would say it's a tohu and it's a bit like… One of the experiences we had was a few months ago, and we had gotten a collection of tohu that made up

a aitua. And I think it's around what we do with it at the end. Now my sister had an experience in Australia and she rang back and we worked it through. And through this she had, I don't know whether you call it a vision, she had a very strong recollection of a young man on a hill called Daniel. She didn't know who it was, and that was fine. And we didn't click. That was the first tohu that we didn't pick up. Then my niece came back from Australia and we went down to Putiki marae to see her aunty. She came back from America and she hadn't seen her aunty since her aunty passed away about three or four years. They went to the urupa and we were on the other side and we waited and we called them in. And then when we went to do the karanga there was a pause, not quite a break but a pause. And then the tears started to flow. That was the second tohu. Oh no, the second tohu was on Friday night, that there was a very heavy feeling that something wasn't right. So what we did was we rang around to see if our boys were alright. We just had this understanding that it wasn't right. So we rang around. That was the second tohu. The third tohu was at the urupa, down at Putiki. The fourth tohu was at Aramoho when we went to see our parents. We all went up as a family. And the waiata that was sung was the waiata that was prepared but it was like for a mate. That was the fourth one. That night we didn't actually sit down and hui as a whanau to talk these things through. We'd kind of like, I'd spoken to someone and someone else had spoken to someone but we hadn't sat down as a group. What we actually found was that, that night our nephew Daniel got killed up in Rotorua. And yet we hadn't sat down and connected things up. And we thought for us, Daniel was the aitua. He, through all things that pass through this world there's something good that can come from things, and that's what we've been taught. And it was about the ability to have actually sat and talked as a whanau about these things. Because while we'll have different feelings or different thoughts being together is actually the strength of finding the answers. And it's been quite sad because we had to go back and actually sit with the family and talk them through it. Because what that family is going through now is exactly what we went through close to 35 years ago when our brother got killed the same way. And it's kind of like history repeating itself in saying that well these are a collection of tohu, this is an aitua. This was an unplanned response to things that have happened.

Miscarriage

And they say that when, through conception, that the embryo moves through a particular cycle and as it grows and matures it gets to a particular stage, that aitua stage. That it has the ability to stay or go. And then in most situations when it progresses, it turns, it is born into this world. Whai ao ki te ao marama. And it's that progression, and I understand that when it gets to that point, and it's taken, that it never goes to the marae. Like, because they've never seen the light of day. And in actual fact they're buried like a whenua but it's not a whenua but goes to the urupa because it was never the role to come into this world. But did it achieve what it was supposed to achieve? Did it bring about a path of thinking or understanding that produced a strength for a family. And that's probably what, and I'm probably thinking about years ago when I miscarried after my daughter, and my parents came straight up. My Mum started praying and throwing water all over the place, and I'm thinking 'oh my God, here we go.' And at that time we were in the Rotorua Hospital. All these Pakeha people were so surprised. And anyway, what had happened was that she came, I told her that I had gone to hospital and they had taken me on the ambulance, up from Whanganui to Rotorua. They were up by the end of the day. She came up and she did me with water, and she asked me, 'had I been given anything?' because I hadn't had any tohu. Had I been given something or did I have something that wasn't mine. And from what I found, then I remembered that about a month or a couple of months earlier I had been given a ring, by my husband at that time, from one of his family members. She asked me where it was and I said it was back at the house somewhere. And she asked me what the circumstances were for passing this ring over. It was my sister in-law and she had open heart surgery. But she had been involved in a gay relationship in Waikato and it hadn't gone down well with her partners whanau in Waikato. So as a result, my mum came up, she not only did me up, and my husband and our daughter at that time, she also did our house up. And she got the ring and she buried it. And she went, I watched her go around the backyard, do all these other bits and pieces, go through the process of karakia, and clearing. And then I found out later that from her understanding that it was a transfer of aitua and going back that way. And we were very fortunate that she'd been able to pick it up at an early stage. And I think at that time I probably was about four months pregnant. And that understand that in those situations, because you normally think 'ok, that's a mate,' and the mate goes to the marae, but because of the type of mate, and the type of mate was that it was never born into this world in the proper fashion, so it still belonged in the world of darkness so therefore was taken straight to the urupa and was buried accordingly. I think it was buried on top of my grandfather. Yea, and those sorts of things, so through my own experiences I've learnt, it's been a type of wananga, the progression stage. When my sister had a still-born we were watching the process and being explained to her around those sorts of things. Now her still-born was treated the same way as a miscarriage. While it was full term, that baby still had not seen the light of day and was still in the darkness. So even though they had a casket, and because she was full term, gosh she was a big baby too, two pounds. And so they put her in a little casket and they actually took her back to Levin, to Hokio beach. And so that's where she was buried. But she never went to the marae and she never went that way. And I think the other thing too is, and this is a part of whakapapa, where in actual fact, because these baby's can be easily forgotten, you

know as a parent you remember them because it was your experience. But a brother or sister later down the line or grandparents, you know, the child is usually forgotten, unless something changes that.

So in terms of miscarriages, and aitua, and the discussions around aitua, and I think the concept has been around, it's always a bad omen. But I'm not quite sure. But I think that's based on our own whakaaro of today. Then we've turned it into something bad. It's a bit like makutu. They say makutu is a really bad thing. And yet I know in Maori it's reciprocal, you know. And the same in terms of aitua. And that was the understanding we've had, is that there's a balance. I think they call it a dark side and a light side. White and black side, whichever side you like to say. But there was always two sides, and it was around a balance. So in terms of aitua, and they usually say that in terms of some families, there's always one that don't have children. And they say that that's, some call it makutu, some call it aitua. But it depends on your own perception. And we've always been bought up to believe that there is, for every one side there is always a mirror, there are two sides to every story.

Rongoa

That's the strength of the whanau. We have always been proactive of life in terms of whakapapa, and that's really good and that's what we stand for now. But I think from my understandings and what I've been told, and read through waiata and whakapapa lines is that living rurally and coastal, because Nga Rauru is coastal, that in order to keep the whanau strong, you only carried those that could carry themselves. So even looking back, we never heard of babys with club feet, we never heard of any of these sorts of things. Because abortion was set to maintain the strength of the whanau. And that's what we understood. Abortion did happen. It was a decision of the whanau though. It wasn't a decision of a person. And it had to be done in the best interests of the whanau. If children were born with defects, simply because they couldn't carry their weight. Because they were working whanau; six months inland, six months coastal. Carrying baby, as well as food, as well as those sorts of things, became a strain. And from what I understand, it was about collective good. And that it was the root of the harakeke that was used. But there was a process used, it wasn't just a matter of aborting. It was a matter of ensuring, like if, in waiata you find the best form of historical records because in there, we've got a waiata back home, you've just reminded me actually, where a women's baby was taken but she was given another baby to breast feed. And her baby was taken because of the defects. So it was the whanau decision but in order to make use of the milk. I mean from my point of view today, I don't know if I could cope in that situation because the environment we live in today is quite different. But I believe if I was nurtured of those times, it would've been an acceptable thing. You know, and it's a bit like death. When someone died, and I remembered this through when my father died, my mum was sitting on, one of my aunties said, 'did you know…' that my mother was supposed to be matched-made and she ran away and she ended up with my dad and came back to Whanganui. Anyway, he died, and then straight after burying him they would've had another husband there for her. And that was to ensure that the tamariki and mokopuna were fed. We see it today as, 'oh, filthy brute!' but from their point of view it was actually around keeping the whanau safe. And I think when we talk about sexuality and reproductive health, if whanau was the pinnacle of our survival, it's quite understandable that abortion would have taken place. It's quite understandable that, well let's put it this way, if you had a child that was born a real maremare, you know the time and energy spent on maintaining that child would actually take away another persons contribution to the wellbeing of the family. And I suppose those were the hard and fast rules that kept whanau strong. And I think that as time moved on, well with colonisation we changed a lot of that. I think with Koko, and with my own parents, both from strong backgrounds in terms of whanau, that they believe that that's the pinnacle of all things. And they taught closet-like, they didn't teach openly. Koko always said that what's out there I can't control, but what you learn here I can. And therefore this is the way it's done. And so that's the way in which we learnt. So a lot of the concepts were laid by our grandparents, and our parents reinforced them in every day life, in daily living, in selecting partners, relationships. I have 5 children who have very strong understandings, two 20-year olds who won't leave home. And while all my of sisters and my brother we bring up our children differently, but we have the basic value of whanau. So for me, everything to do with sexuality and reproductive health goes back to that.

Rongoa And Abortion

I remember having trouble with my mate at one time. I remember thinking that I was hapu, and I'd not long had my twins. And my mum said, 'Oh my God, what are we going to do?' So she got in touch with her cousin. And she said, we have this whiskey and you're going to have a hot, hot bath, and I thought, 'God I don't know what this is going to do.' But it was actually after they had met, they had spoken in preparation of abortion. And that was when I went, 'Oh my God, the bath is so hot.' And at that time I'd only mentioned that I thought that I might be. So as a result, they had a hui. And then they came together and they found out that I wasn't. But they had prepared all the rongoa to start the process. And I think it would've taken a period of, the rongoa would've taken probably about half an hour. And I think the clearing process and the mirimiri would have taken at least 48 hours. And the whiskey, well you just would've been numb. Because I'm not a drinker so it would've had a huge effect on

me. And I think I probably was in my twenties at that time, late twenties. So they met and discussed it, and the strength of the harakeke, because you can use the juice not only to clean out but also to create abortion. It's a bit like a curette sort of thing. And the different parts, the juice, the root itself, and what happens to it. And so that was my experience with my mother's theory of abortion.

And so I believe it happened. From my understanding, it happened. I think today, because our lifestyle is a lot more comfortable, I personally don't agree with abortion, unnecessary abortion. But I do know that there are situations where life and death, where those sort of risks such as abortion can be necessary. But personally I believe that the whanau have a responsibility to anyone in their own whanau in that position. And I think it's around our whanaungatanga, we don't always. And Whanaungatanga becomes our monitoring tool for letting people know if we're alright. I mean I know when one of my sisters aren't right because they either avoid me or they have characteristics that alert me to when things aren't ok. So that allows me to keep in touch with them. But personally I don't agree with it because we have too many resources, too many other avenues of access.

Whanau

There are high levels of teen pregnancy, high levels of STI's, and it's happening. And I think a lot of it is that, no matter what we try to do with the rangatahi, it's the families that actually need the educating. Because I believe that, in terms of our own Maori thinking, all our teachings begin at home long before our rangatahi become active. All their thinking and their concepts around relationships and what's acceptable, is learnt in the home or the environment that's nurtured them. Good or bad, it's nurtured them and it's created their experiences. So we hope that promotion will make at least a small degree of change but realistically in terms of the kaupapa the focus needs to be within the whanau. The whanau is not just a Mum and Dad and a child, it's actually the aunty, the uncle, all these grandparents, nieces, nephews, cousins, whoever you determine to be your whanau. It might be your cousin brought up with you, those sorts of things. And so I think the kaupapa for sexuality and sexual and reproductive health is whanau. Well I believe that anyway.

Rona And Menstruation

I think that most of our learning around sexuality is really learnt prior to becoming sexually active. It's just my hope that we find strategies that work, and work soon. One of the ways that we're learning to do that is through our own Maori thinking; restoring those practices. This is what we're starting to use now, to teach around the menstruation cycle, Rona and the moon. And while that's the legend, it's what was Rona's relationship to the moon, you know with the universal law of her body. And so it's about saying, yes, like the moon, the menstruation cycle comes each month, rises, reaches a pinnacle and dies, to be reborn. And these are some of the easy concepts that our own Maori thinking have had for generations. So it's about that sort of restoration of thinking. So those are some of the teaching tools.

Ranginui And Papatuanuku

Ranginui and Papatuanuku. I remember being told by my father when we used to travel to Rotorua, and we used to leave something like four in the morning and stop along Taupo and have a wash, and wash all the pikaru's, and all that sort of thing, and then being around Taupo there was a lot of mist, and he always used to say to us, this is the aftermath of Papatuanuku and Ranginui lying together. Never really fully understanding it until later. But it's always remembering that after making love, after those sorts of things, that there was always an aftermath. And it's something that you could, it's like a relaxation. And so I suppose that's part of that teaching of what's ok and what's not ok. I was probably about 10 when we knew about that. And so it was never an unnatural process to talk around those sorts of things. My mother had very, very strict practices of whenever you had your mate, no one was ever to see the toto. And it had to be dealt with appropriately. And as I got older I thought, my gosh you must've been good to have hidden it every time. My father was never ever aware that she had a mate because she never had those things around the house, they were something very private. It was solely hers to deal with. And that's how she dealt with it. Whereas today you see, men going in and buying sanitary pads or tampons for their partners. Oh gosh that's something that my mother would never ever have, she'd never entertain the thought. And we never ever did those things either. She used to make her own. And then she used to do away with them. And I remember after my sister lost her baby, stillborn, she had to go home for a period of weeks, and mum used to do her up every day. She used to do rongoa to mirimiri her body and bind her puku, and these sorts of things. And it was about preparing her. She only ever had one child after that but had many, many miscarriages. And then they even tried sewing the vagina. And I remember my mun saying, 'If it's not meant to be, let it go. There are other things.'And that was some of the learnings I think we've lost sight of, well not deliberately, it's just become a different way of life now.

He Kaikorero No Tuhoe

Pukorero

I've been having conversations with my own people (about pukorero that illustrate sexual and reproductive health) and it's good, we disagree on things and so we leave it to the side until we're a little bit better informed on how to debate it. But for me, the metaphors, some of the metaphors for me around this topic is the Rangi and Papa story, Tane, the Tane story with Hine Ahu One, the Tane story with Hine Ti Tama, then there's the story of Maui wrestling with Tuna Rua over his assault on his wife Pani, which is supposed to be kind of the premiere Maori mythology around sexual intercourse. We need to look at those things, you know. Then we need to investigate the whole phenomenon of Tiki. We need to have a look and ask what is that saying to you and I. Then there's another story about Maui's relationship with Hine Nui Te Po, about conquering death. So those are the purakau, the korero, the purakau that we really need to sit down and go through bit by bit and take note of what the clues are that are in those mythologies. What is it saying to you and I? And I've had these conversations over the years with people because we need, as Maori people, to make our opinion known about our attitude and about our values, about our virtues, about our ethics, about our standards, and to our own people because that helps us understand how we are supposed to be Maori, you know. Because that's what those things do. Standards tell us what we as Te Ati Haunui a Papaarangi believe in and what are the cohesive standards between us. But those things are unexplained. Those things are unannounced. It kind of demeans our sense of culture, of identity, because we are not too sure how we belong, how we can call ourselves a group, you know. And I think in terms of authenticity, authenticity or to find the root basis for our attitudes, those attitudes we remember our Nanny and our Koro, and our father and mother having, or our Uncles and Aunties, to go back to those myths and legends because that's where they are. They're not lullabies those things. They're actually very clever information storage mechanisms, wrapped in the fantastic, but the essence, the moral of the story is embedded in there. So when you take away the fantastic feats and the phenomenal, in there is the moral. And those are the things that we need to pull out and say, 'Hey, what is this saying to us?' 'How is that connected to our practise, how is that connected to our attitude?' Because if you and I were to try and define or describe Maori sexual and reproductive health, as of now it would be, we have to acknowledge that it's highly distorted by Christianity, it's highly distorted by other factors. And it would be quite an error for us to say 'this is the Maori viewpoint' without, you know if we only have a four-year memory, you know, or a five-year memory.

I think it's important that pukorero, some pukorero be investigated, myths and legends. I'm not giving a complete list but I've identified for you some of them which I think are important that I've done a little bit of thinking around. So I've sort of scribbled down some of my thoughts around some of the themes and the morals of those stories, which I think may be useful things to investigate. I don't know if you want me to cover those?

The tikanga regarding, for example mate wahine, I think that sets some precedence around sexuality and reproductive health in terms of how do we explain that culturally, what's our interpretation of that, and how do we deal with that whole phenomena? There's a lot of stuff there, especially about do's and don'ts, and our regard and our explanation of it is really interesting, how Maori explain it. As you have said, in the Western world which you and I are a part of, it's a medical phenomena so that's its explanation, you know. If you want to call that cultural, well there you have it, there's your cultural explanation. But there's also, we need to relate issues around tapu and noa, about those concepts. How do they impact on reproduction and sexuality? And also practices like kaikotore, we have this at home. There's this history when one is betrothed, and tono'ed as a taumau with somebody, there's this great feast and gift exchange called the kaikotore, where there are certain intentions and there are certain promises and pledges that are made which involve sexual behaviour and reproduction expectations. And when marriage, there was a Maori marriage ceremony called the pakuwha which with gifting and feasting etc., and with karakia ceremony around it, all that is kind of long forgotten and displaced. So we are interested in, what was involved there, what were they actually celebrating? In the karakia, what did the karakia refer to? To which atua? To which phenomena? Because all karakia have idealism and expectation built into them. So we're interested in what was that? What was all of that about? What were they saying? What were they saying to the couple? What were they saying to the father involved, and the hapu? Because that gives us clues around that. Even the taumau or the tono, how did that work? That betrothing, of people, sometimes it was young children. We realise that there was a economic and political motive running there. But what were the more physical, personal stuff as well? There must have been some there. What happens when things go wrong? When there's a collective expectation and all of that but for whatever reason breaks down. How do you deal with that? How does one deal with that? Because the ignominy is not just of the individuals but of iwi, hapu, you know. Like the intended marriage, and one of the partners then is violated by another. That's the violation of a hapu, a iwi, that kind of thing, you know. And also I think there might be some clues that we would get around those love charm karakia…

So it's those things. In carving as well there's a lot of symbolism about sexual and reproduction found in the pare over the door. There's a lot of korero around that and that's the lintel, the door lintel there. The door lintel is a phenomenal cultural statement about life, about sustainability, about sexuality. So we need to investigate that.

Waka

The fact that in our own culture, we have a particular way of symbolising femininity and symbolising masculinity. You're not allowed to mix your metaphors and your symbols. Women for example get the waka symbol. Men get the tree symbol. You know. And so it is when you investigate waiata, and especially if you divvy up your waiata, those authored by women and those authored by men, and you look through that. Very interesting about their preference for imagery, you know. And it's very telling you know about that view and how much of that has carried on, you know. For example, songs written by women are very direct. They're very direct on the topic. The women have very little difficulty in expressing their emotions and their feelings and their thoughts. Men have to do it through a third party and usually it's symbolism. So when men want to express their disappointment they do things like 'The tree has fallen, the star has faded, the moon has waned, the tide has withdrawn.' Whereas women say, 'shit I feel bad about this.' You know, 'this is crap, and I'm hurt, I'm devastated,' etc. But men like to express it in a different way.

The other thing is that canoes, the canoe is a very much a prized female symbol and imagery. The carrier of something. And the shape of the canoe itself is very sexual. But it carries people, it carries cargo. It enables people to go from one destination to another, which is about continuity, intergenerational survival. And when a matriarch dies, guess what - it's called, in songs the saying's 'the keel has broken,' 'the hull has been damaged,' 'the canoe sinks.' Waka metaphors, eh. So those are examples.

Waiata/Haka

I think there are many examples within haka, waiata... For example, I found examples of waiata where women are challenging each other, women of different hapu or even of different tribes, where they are in dispute of some kind. And the way they insult each other. In Western culture, people insult each other by using genitalia. In Maori they don't do that. The best way of insulting somebody is to prove that they serve no purpose. One, you're isolated. You profoundly affect somebody when you tell them they're disconnected, they have no primary role or connection to anyone of any importance. They are not an affecter. But they are a dependent. And the greatest insult is to say that none of those things [purpose, etc.] exist in their lives. And so even looking at the way Maori disparage and swear at each other, I think it is of interest in this case to see if at all, if there is any reference to sexuality, or reproduction. There's very little in my view. And that's significant in contrast to the society you and I live in. Because that very important thing is using it in a demeaning way. Not so here. There are sexual references in some waiata, in some haka, but the way they treat it is quite different. The way they are being used is quite different. So that's of interest to us as well. So now there's that whole host of things which I think brings some distinction of our knowledge around, our cultural stance.

Pare

So for example about the pare, the door lintel. And again this is my own investigations. The pare, or the door lintel of the wharenui, enables us to mark the inside of the house to the porch of the house, or verandah of the house, to the marae of the house. These are three distinct places. Inside of the house is normally regarded, by humans or mortals, almost regarded as akin to Hawaiiki, the next world, the spiritual world, the world where we all originated, and the world to which our spirits return. Because the inside of the house is regarded as warm, safe, where no violence occurs. And the greatest thing of all is, you're with everyone that you love. It's crowded.

The porch is a twilight zone. And to even recognise that there is a twilight zone between inside and out is significant. And the formal word/term given to that area is Te Mahau Tare are a nui a Maui, which in short translation means something like, the great struggle of Maui as Maui went to seek immortality.

Then you have the third space, which is the marae atea, which is symbolic of Te Ao Tu, the physical world, the real world, the natural world that we live in. Now that world is unpredictable. We don't control the weather, the elements, and so as man sits in life, he is largely not in control, ok, largely not in control of his world. As opposed to inside the house, where it is a prescribed climate, it is a prescribed environment.

So here you have these three elements. And the significant passage, right of passage, is overseen by the pare. And on the pare is Hine Nui Te Po. Not here symbolic of death so much. But here she is the marker of the transition, the transcending from physical life to spiritual life. And you go through the door and through and under Hine Nui Te Po. She is your guide, she guides your spirit through that twilight zone of the porch and the veranda, where anything can go wrong because that's where Whiro, whose unwavering and eternal ambition is to destroy all of Tane's descendants to ensure that their spirit never gets back to Io, inside the house. So Hine Nui Te Po stands tall over the veranda, saying to you as you are on your marae, and as you come into the house, 'this way, this way.' It's a portal, this is a portal. She's the beacon to ensure that you're toi ora, your life essence, your wairua, makes it across that divide. Huge symbols there. And her power is her sexuality. The uwha, her

femininity. That's her power. Because it was that that bought forth humanity and mortal life, and who will ensure that mortal life can actually be transformed again into spirit. Humanity originates from spirit and so it can return to spirit.
See this is the philosophy, this is the ideology. Huge symbolic significance of the whare. And the totems on each side of the door, the door jams, that support the pare, are the only Maori art that is totem-like in its representation. It has to be, not only because of the shape of the door, but the fact that it symbolises the continuity of life, whakapapa. It say's, You were, you are now. But there's somebody else. And then there will be somebody else after that. And then there'll be somebody else after that.

Rangi And Papa And Creation Of Human Beings

My understanding is that it was Rangi and Papa, not Tane, that went out to look for the female element. It was Rangi and Papa that required it. When Rangi and Papa were still together, with all of their children between them, it was Rangi and Papa's notion, it was their idea for humanity to be created. And so there was this great search for the elements from which mortals could be created. But you see Maori stories have been so cut back and edited that we're not getting the full version of them anymore. You know, we've kind of got to the Warehouse version…
So it was really Rangi and Papa that started this whole thing. Now to me that's significant. We need to sit down and say, 'Hang on, if that is a fact, if it wasn't really Tane's idea, Tane was just a respondent to the plea for humanity, what the hell does that mean? It has a different angle now. So all of the sons of Rangi and Papa went out looking for the uwha, the female element... They couldn't find it. So they all got together, Rangi / Papa and all the sons got together and then said, 'well, because it doesn't exist it has to be created.' That was the conclusion. It doesn't exist so it has to be created. Ok, so how do we create it? Then Tane gets a clue from Ranginui, his father. Rangi says to him, 'well it ain't up here. Yes, you can create the human element but the essential parts are not here. They're down there. They're with Papa, not here.' Mmmm, well that was a clue. So remember the sons are going out trying to figure out 'now how do we create the feminine element which we need?' Then on his quest for knowledge, on his way up in the 11th heaven, Tane is told by the demi-Gods there where he will find it. And then pointed Tane of course to Kurawaka, to this place called kurawaka, which was in terms of the form of tapa, you know, where her genitals would be. That's where you go and create this female element. So Tane got a clue. So the story goes that the production, or the design of humanity, was a collective effort between Tane and his brothers, the demi-Gods, Rangi and Papa, Io, everybody, which is a different angle from Tane went out, got a bit of clay, took a night class, and there you have it. And there you have it, almost in the Greek kind of way. Yes, it was a crusade of its own and should be described as that. So I think it lacks the fact that humanity was this crusade, it was this challenge. Can we do it? Does it exist?
So then the story leaps to, all of the sons end up at kurawaka, at this place. And so from the earth they create the shape and the form of a woman. And each one of the children of Rangi and Papa contributes something of themselves in the creation of the first human being. And the first human being is not a male, it was a female. So life is best expressed through a woman. If ever in our culture you want a symbol for life, women not men, not males. Because the first mortal is a woman, and that first mortal was made of earth, more earth element than, well, it's a combination of sky and earth element, if you like, celestial and temperal elements. If you like, intellectual, spiritual, metaphysical elements and physical elements, eh. See, those are all codes for that. If you want to put it in our language, you and I would say, well it's metaphysical, the thinking capacity of human beings. It's almost electronic and impulse based. Whereas, as opposed to this, which is tangible. So we're a mixture of those, and this is how Maori speak about that, elements of Rangi and Papa. But it's been woven into a story which is easier to remember but more difficult to decode. But it has I think all of those detail and data in it…

Creation Of The First Human

And kura being very important. Kura being something vital, something important, something of high value. So at Kurawaka you then have all of these contributers. Like Tiwhaia gave his eye, and that's the female organ. The eye, the eye of Tiwhaia. Tane accepted that. And then Punaweko gave the hair. And then the blood and the spirit came from Io, but through Rehua. Rehua, one of the demi-God's, went and asked Io. Io said, 'here, here's the blood, here's the spirit, here's the life essence,' which is that thing that makes life work, gives life form, 'here it is.' So all of that came from them. Then Tawhirimatea gives the lungs. Ruatepupuke and Whatukura gives thought, intellect, reasoning, imagination. And then the eyes were given by Uru, the eldest child of Rangi and Papa. The ability to see, to visualise, came from the eldest child of Rangi and Papa, Uru. Uru-te-ngangana a Whatu. The whites of the eyes was given by another brother who is the spirit of clouds. So the whites of our eyes then comes from, Aowhaturia, comes from Aokapua, another brother. Tupai, a demi-God, gives the bones, the skeletal system. Tu and Akakamatua then gives all of the sinew, the muscles. And the list goes on, of the stomach, the throat, and the arero, the ihu, and the lips. But in essence we are the product of this great innovation, this great research, where everybody contributed. And finally this thing was finished. And so the ira tangata, mortals were created by immortals. And the essence of the mortals were the gifts by the immortals. But we had a distinct difference to them. We were mortal, we were their creation. So Tane is

seen as the progenetor. He carried the seed of life and the woman created, Hine Ahu One or Hine Hau One, is the carrier of the seed. You know, so there are all of these metaphors where Hine Hau One is the Papaahu, the fertile ground, the kauwaka, the vessel. And so these are all the beginning of the sexual reproductive terms, isn't it? The male Tane, being the seed carrier, the fertiliser, active/passive, eh, when you think active / passive, almost a creation of personality, of character, isn't it, that's coming into play.

So after that, life is breathed into her. She sneezes, now this is significant. The significance of which is lost on us. Why didn't she burp? As researchers we would have to ask, 'well, why a sneeze?' Now that's significant. Maybe you and I don't really fully appreciate the significance of the sneeze. Apparently in Maori it means you're alive. Whereas, I wonder what other behaviour would have been appropriate or inappropriate, I don't know. We just need to ask those questions, why a sneeze? And then it's immortalised by the words 'tihei mauri ora.' You know, it's immortalised. Was this an accident, or what? Or was this by design? So we need to ask these questions. So she sneezes, she wakes up, and she breathes. Then she's taken for a tohi ceremony at, according to some versions, the name of the waters is Hauparoa, where she's kind of symbolically cleansed. And the name of the place is Mauritakena, talking about the mauri, te mauri of the person, that's where she is taken. And this ritual and ceremony is done. And after that, Tane then attempts to copulate and then create man, but he doesn't know what to do. So then we get tears, then we get hupe. So there is this clumsiness, in this story there is this clumsiness about sexuality. Now we've created this woman but how does it work? How does this work? In our storyline, this experimentation goes on, and all of these errors. I mean, if he was a student he would've failed the course. I think he had around about five call-backs kind of thing, five extensions. That's better than now, I think you only get one extension per paper. Now you're out. Sorry you failed the course. But Tane then has all of these things and then finally he does it. And so the tapu of Hine Hau One is complete, is completed.

And then she bears a child. And so there is a saying then, 'titama te ao, titama te po.' Which is always a play on words where the night and the day have started. But her name becomes Hine Titama. Titama te po, titama te ao. And it's a saying about, this is truly life, this is the heir of this union. It works. The whole damn thing now works. Hine Titama is born, we are told in Pipiri, Aonui-pipiri, which is why we have the new year in June. Yea, that's when Matariki is. That's the time when Hine Titama was born. And the time is Orongonui and she was born inside the house of Tane-huiteananui. And it was the demi-God Tupai that performed the naming ceremony over her when she was born, inside the whare and where she was named Hine Titama.

Hine Nui Te Po

When she found that her father and her husband were both the same person, we then have to analyse, this is the beginning of morality, this is the beginning of standards. Remember, Tane is a God, moralities are human inventions, eh. It's humans that need morals and standards and values and virtues. These are not the bywords and requirements of a God. So it was Hine Titama that was the precursor, the originator of the human need for these guidelines or standards. And it was her that discovered that there was something wrong. This is not a good look, this is not a good picture that my father and my husband are the same person. This is just not right with humanity. But with Gods it's irrelevant. So here we have the invention of all of those things, which impinges on sexuality and reproduction because you can't separate them. So again, there's that investigation. Once she finds this out, she then, this is after she's had 12 daughters to Tane herself, but once she discovers this out she then abandons the whole family. Puts all of the children to sleep and takes off. And it is said that she goes to a place called Poutererangi and arrives and meets up with a person called Kuwatawata, who she pleads with, pleads with him to allow her to go to Rarohenga, the underworld, from where she will guard the life principle of all her descendants because she can not stand Tane anymore because of what she sees as the betrayal, eh. She can't live with him anymore. Kuwatawata doesn't know what the hells going on but her pleading is affective. So he lets her pass but warns her that once she goes to Rarohenga she cannot come back. It's permanent. She accepts that as the price because she says 'at least there, every one of my children will pass by me, even though I'm absent in Te Ao Turoa, Te Ao Marama, I will guide them in Te Ao Wairua. So she's let past. And that's why then, that very act tells us that we are safe. Our wellbeing is safe because of that act. So Hine Titama, aka Hine Nui Te Po, is much maligned; Goddess of Death. Wrong, wrong. Bad person. This is the Darth Vader of Maoridom. Not true. Spiritual guide, spiritual light, yes, but not the wicked witch from the West, you know, who goes around killing, slaughtering people. Not so but this is why our spirits are able to return…

It is said that once Tane found out that she had taken off and put all of the children to sleep, he was overcome really with pain. Now this is unusual for a God. He started weeping and crying, Tane did for Hine Titama, and chased her. These are now mortal feelings. He is overcome and so there's some affect. The story here is saying to us, that we have effect in the spiritual world. As the spiritual world has created us but there is also an affect that we have. This is most interesting philosophically. And I'm just saying to you, none of this has been explored at all, you know, in a hundred years of Maori literature, this type of

kind of analysis of this stuff, you know. So Tane chases after her. And as she is disappearing to Rarohenga, he is on the other side pleading with her to come back. And she said 'no.' And from where she stood, where she could no longer return, she recited this karakia over Tane, which causes him to get an adams apple, a tenga, or what other people call a ponawhakahorokai. That adams apple that only men have. And interestingly, that tenga, the ponawhakahorokai, the adams apple is caught in the middle of the throat, between the mouth and then the stomach. In between. You can see it. It's a peculiar phenomena only found in men. It's in the throat, in between. Life and death. Or Life and death, whichever way you want to hear, caught in between, that's Tane. And Hine Titama said, 'This is the sign. I want to give you this. This is the sign. This will immortalise for all of our descendants what has happened here, this phenomena of life and death. Ok so that comes. So Tane, so here again we have our second example, of humanity affecting Gods through a karakia. So then she disappears and becomes Hine Nui Te Po, the protector of humanity. Not the destroyer of humanity as we have been led to believe. Hell, this would mean a huge curriculum change in this country. Isn't it? A rewrite of everything. Hine Titama, it is said by our people, Titama also means the dawn. So if Hine Titama is the dawn she rises in the East and then rests in the West. And after her the sun is, Tane is alive with the sun. The dawn made in Hine Titama rises, and is chased by the sun across the sky. And she disappears into the West. And by the time Tane the sun gets there, she's gone to Rarohenga. So then he comes back again and chases her again the next day, and the next day. The sun is Tane, the dawn is Hine Titama. The sun chases the dawn and never catches it. And will never catch it. So he tries every day. He attempts it every day. So the day is symbolic of our humanity and this sexual health that you're talking about. The day, the sun chasing the dawn. The dawn always makes it to the West to Rarohenga, it disappears. The whole thing is relived, reacted. It is re-presented to you and I every day. But Tane is resolute, and try and try and try every day. He will not give in. So every day he does it, East to West. She flees and hides from him. She is a Hine-ngaro. She's the maiden that is always lost from Tane. She is the maiden that is always lost. The hine-hingaro.

Pani And Tunanui

It's the same story with Maui and Hine Nui Te Po when he was seeking immortality, that whole story is good to break down. Also about the tuna, you see. If anything, that's the phallic symbol in Maori world, you know. When Pani, in one version, Pani, the wife of Maui, goes back and says, 'well I was down the river, swimming, minding my own bloody business, and this eel comes along and sexually assaults me.' So Maui goes down and hunts him down, Tunanui. Traps him, cuts him up into pieces, chucks his parts all over the place. You know, the head lands in the sea and becomes the conger eel. The tail lands in the rivers and then is the progenator of all eels. The body parts. And explains the profusion of all these other reptiles and animals, you know. But in certain parts when, the eel has survived into Maori poetry as, I wouldn't know what the term is but, the tail of the eel is used in some iwi nations as the, a philanderer, as the adulterer, ok. When you say hikurekareka, the hikurekareka, the tail, the stimulater, the hikurekareka of the eel, it's a poetic way of saying philanderer, adulterer, that kind of thing…

He Kaikorero No Ngati Kahungunu

Extract From Upcoming Ph.D : Whakapapa Korero, Tangata Whenua and Turangawaewae: A Case Study of the Colonisation of Indigenous Knowledge, Ph.D in Education, University of Auckland, Takirirangi Smith.

Tikanga Tukuwhenua And Whangai

In colonial European society adopted children and land succession and occupation rights differed greatly from precolonial Maori society. Legitimacy or 'take' to land and other taonga was held within whakapapa korero. Genealogy or pedigree was never the sole determining factor. Of critical importance was korero which explained the nature of particular relationships and identified the 'take' or reason why a particular relationship had validity. In pre-colonial Maori society children did not have a sole parent in the European sense. A child's parent (matua) as well as a birth parent also referred to the brothers and sisters and often to cousins of birth parents. Maori Land Court evidence provides numerous examples of where apparently unrelated individuals (in the European sense) are referred to as "taku matua" (my elder/ parent), "taku tamaiti" (my child), "taku tama" (my son), "taku tamahine" (my daughter). At the level of the parent's generation, cousins are referred to as brothers and sisters, "he tuahine noku" (she is a sister of mine), "koia toku tuakana" (he is my older brother).

The division of labour and communal lifestyle in pre-colonial Wairarapa meant that children were at times absent for long periods from birth parents. The seasonal nature of food resources meant that in winter some males could be away for days engaged in birdsnaring, attending eel weirs or some other activity. Women also spent some periods away from the kainga,

gathering berries, and raupo for houses, weaving materials or other resources for survival and maintenance of ahikaa. In the warmer months whanau moved in groups to coastal areas. Men spent long periods either fishing or preparing for fishing and women spent long periods gathering and preparing foods, for example dried shellfish, for the winter months. From the age of about seven children commenced a formal type of learning in various skills, which for boys included knowledge related to warfare, agriculture, birdspearing and snaring. No individual taught the whole curriculum, but instead designated individuals and specialists within the whanau or hapu shared the responsibility. Children by the age of twelve to thirteen, who had been identified as suitable for learning within particular branches of knowledge, commenced working alongside adults. According to early Maori language manuscript accounts,[191] some children were selected to commence a more formal and sacred type of learning in the whare Wananga where the philosophical teachings of the tribe were taught. Whakapapa korero narratives learnt in the whare wananga were important as they contained the knowledge and the templates for survival within the local environment.

Within this context, where children had many parents within an extended family and belonged to a kainga, there is no evidence of the term whangai tamaiti being applicable to children within the kainga. The notion of an 'aunt' or 'uncle', or grandparent having a whangai child while belonging to the same kainga, and contributing to the same economic unit as the birth parents is not present in pre-colonial Maori evidence. Whangai were brought up away from the same economic unit as the birth parents.

The earliest tamaiti whangai discussed in whakapapa korero narratives is the story of Maui tikitiki a Taranga.[192] Wairarapa accounts of this story are varied in detail but the key events are the same; Maui is born prematurely and his birth is aborted, he is wrapped in his mother's topknot and cast into the sea. He is found by a grandparent who nurses him back to health and educates him. When he reaches adulthood he reunites with his family and performs a number of acts for the benefit of future generations.

Stories about Maui have been popularised in European literature and children's books where a genre has been created commonly referred to as the "Maui myths". Some of these versions popularise the idea that Maui was an abandoned child and thrown into the sea. These stories conflict with early Maori manuscript accounts, which suggest that great care, was taken by the mother in relation to her aborted child. The steps taken by the mother, the cutting of her topknot, and wrapping Maui in it, and placing him in water, bear relationship to a number of ritual procedures that occurred in pre-colonial times. These rituals are generally classified as whangai atua. In early manuscript accounts whangai atua are acts of offering to an Atua or spirit. Atua are supernatural forces beyond which maintain the existing world. Pre-colonial Maori, at the beginning of seasons of food gathering and harvest made offerings to guardian atua or poutiriao. These guardian atua or kaitiaki are said to protect the domains and maintain the balance of the environments that they look after. A related custom is called whangai tipua[193] where an offering is made to a tipua in the form of a rock, tree or some other physical representation, allowing safe passage for travellers passing through an area. An example of whangai tipua are acts that were regularly performed in former times at a rock called Tokaarangi, near Greytown.[194]

Another form of whangai atua is called whangai hau[195] and has similarities to the actions carried out by Taranga, the mother of Maui. In this example, the hau (part of an individuals sacred spiritual being) of an individual, in the form of hair from the topknot, is offered to an Atua. This ceremony is said to have taken place at sea. If bad weather was encountered and lives were at risk, hair from the topknot of an ariki or chieftain was taken, and as the ritual expert chanted incantations the hair was cast into the sea. The text of these incantations are offerings to Atua seeking to address the stormy conditions and restore peace in order to save lives that are at risk. Amongst Ngati kahungunu the whangai atua custom has been used up until quite recent years. Prior to entering the sea for the purpose of gathering kaimoana, a hair would be taken from the harvester and cast into the water.[196]

The notion of Maui as an abortion, carelessly abandoned by the mother and thrown into the sea, as recounted in many popular accounts of the Maui story is contradicted in whakapapa korero accounts. These accounts describe how the mother, in an effort to save her son sacrifices one of the most sacred and tapu parts of her body, her topknot, and offers it (whangai) to an Atua as a desperate act to restore life to her son. Maui is educated by his grandparents in a different way from his brothers.

191 Eg, Pukapuka whakapapa korero accounts in Maori Purposes Fund Board Manuscripts 189, Series B, ATL

192 Wairarapa accounts of Maui can be found in New Zealand Maori Purposes Fund Board Manuscripts 189, Series, Folders 1, 7, 10 and 25

193 Translated in Williams 2002:458 as goblin, demon or object of terror.

194 Best, E. 1982: 525, Maori Religion and Mythology Part 2

195 Ibid, 1982: 609

196 Ngati Kahungunu kaumatua, Heke Morris. Personal communication, November, 2003.

Maui has a close relationship with atua throughout his life, and is therefore is assumed to be a tapu individual with mana. The following sections provide further examples of whangai and whakapapa korero.

Another example of the special status accorded whangai in pre-colonial times and unique to Ngati Kahungunu, is the story of Uenuku Titi.[197] She is described as the daughter of an adulterous relationship with one of Tamatea's wives. Her father was Uenukurangi, said to be an Atua. At birth it was thought that she was dead, and incantations were carried out over her by the tohunga. Her father fetched her from where the ceremonies were carried out and took her across the sea to be brought up. She was a half brother to Ranginui and a half brother to Kahungunu.

One version[198] recounts how Ranginui and Kahungunu grew up and one day an adult girl arrived at Tamatea's house. Tamatea's first wife Ihuparapara was weaving inside. The girl climbed inside through the window and over the bed of Tamatea. The woman asked, why did you come through the window instead of the door, to trample the sleeping place of Tamatea? The girl replied, "It is alright, he is a parent of mine". The woman said, "A parent of yours? Who are you to sit on the bed of a chiefly ariki, whose head is adorned with the sacred comb and feather adornment, and who was blessed at the sacred waters of Moana a Kura? The girl replied "Woman! was it not you who carried me to the sacred altar of Titirangi? So why do you complain about me now?"

The woman said "so it is you" and she replied yes. The woman asked where did you stay? The girl said far beyond across the sea, where my elders and parents nurtured me. I was sent to see you both, and my brothers also. The girl then enquired as to what was buried outside. The woman replied that it was a sacred earth oven for her brothers. The girl said let me eat of their sacred earth oven. The woman then instructed the other woman; go; uncover the earth oven so my daughter can eat. Tamatea, Te Rongopatahi, Ruawharo and the other tohunga arrived and agreed that she should eat of the sacred earth oven of her brothers. The tohunga then said, let us all go to the tuahu. The girl agreed and they all went. It was distant and Uenukurangi appeared over the sacred space. The pure[199] was carried out and the three were dedicated to the sacred teachings of the wharekura. On completion of the rituals they returned to the kainga. The first sharing of the ritual oven was given to Uenukutiti to eat. She was then taken to the window of the whare to sit.

The Whakapapa recorded in writing in 1865 after this narrative shows Tamatea as the father;[200]

Rongokako= Maurea
Tamatea= Ihuparapara
1 Uenukutiti
2 Ranginui
3 Tamateaururangi

Iwipupu i a Tamatea
1 Kahungunu
2 Iranui

Ngati Kahungunu traditions also relate the korero of another whangai of later generations. Ngaokoiterangi was a descendant of Tumapuhiaarangi.[201] His tribal people, Aitanga a Tumapuhia lived on the Wairarapa coast. Ngati Ira had been involved in warfare around the Tolaga Bay district and were eventually forced to migrate as a result of a series of defeats by Aitanga a Hauiti and others. They eventually arrived in Wairarapa and resided at Te Kawakawa, now known as Palliser Bay. As a young child Ngaokoiterangi was given to Ngati Ira as a whangai. The purpose of the whangai was to create whakapapa links for Ngati Ira due to the whakapapa of Ngaokoiterangi. On reaching adulthood, Ngaokoiterangi married and had children who intermarried. Ngaokoiterangi decided to return among his own people and quoted what is now a pepeha[202] for Ngai Tumapuhiaarangi. Kia hoki ahau ki te riu o Kaihoata. Ki a Hokowhitu Tumapuhia, putiki makawe tahi heru tu rae anake. (I shall return to the Kaihoata river valley to the company of only chieftains and their symbols of the single topknot and the raised comb of the forehead). Ngaoko returned and settled at Kaihoata. This whangai was carried out specifically for the purpose of

197 New Zealand Maori Purposes Fund Board Manuscripts 189, series B, contains manuscripts which record this story. Although the stories vary with the narrator, the key points and themes are generally the same. See also Best Pohuhu, The Book of Nepia Pohuhu, qMs 1419, ATL.

198 Ibid, folder 7. This version is my own translation of the Matorohanga version recorded by Te Whatahoro.

199 A ceremony for removing tapu after a sacred task has been carried out.

200 New Zealand Maori Purposes Fund Board, manuscripts 189, series B, folder 7.

201 There are various accounts of the story of Tumapuhiaarangi in Ngati Kahungunu manuscripts held by the New Zealand Maori Purposes Fund Board. See also Smith 2001: 13.

202 A tribal saying or proverb.

creating whakapapa links, but may also have been an offering by Ngai Tumapuhiaarangi to avoid warfare with Ngati Ira, in subsequent generations Ngaokoiterangis offspring became known as Ngati Hinewaka and Ngati Ira.

There are some key issues prevalent within the notion and practice of pre-colonial whangai tamaiti. In the Maui korero the notion of Maui being a discarded foetus, premature birth or stillborn thrown into the sea by the mother, as stated or implied in some interpretations of the Maui stories, is not present in early Whakapapa korero narratives about Mauis birth. The whangai rite of addressing an Atua for the protection and restoration of life bears close resemblance to the actions of Taranga, and provides an explanation of the name "tamaiti whangai". Early accounts also indicate that whangai did not actively participate in the daily affairs of the kainga, and were raised away from the kainga. In whakapapa korero whangai were tapu and sacred, and in all cases cited were believed to have mana and were protected by the elderly leadership within whanau and hapu. Decisions about whangai were made by whanau and hapu as well as individuals of the parents and grandparents' generation. There is clear evidence in whakapapa korero that 'adoptees' or whangai were not excluded from land occupation and resources under the concept of tikanga tukuwhenua.

He Kaikorero No Ngati Porou

He aha nga ahuatanga matua e pa ana ki te hauora o te Maori I nga ra o mua , I te ao tawhito e pa ana mo te tai tama wahine me te tama tane

I te mea i whanau mai ahau i wenei wa, he mea me kii, ko toku whakaaro tuatahi mo tera me ki, i tango mai, i hari mai i nga pukapuka, tapiri atu ki tena ko nga korero tonu o aku matua, aku koka me aku kuia, me taku paapa hoki me nga mea taane e tino tata ana ki ahau. I te wa o taku, i te wa o te rangatahi, i a matou e haere ana ki te kura tuatahi, ko to matou koka tonu i te tohutohu i a matau mo nga ahuatanga katoa e pa mai ana kia matou nga mea wahine ,o to matou whanau, koia tonu i te tohutohu.

engari etahi wa ko to matou papa maua ko taku taina. Koia tonu te mea I te tino tohutohu i a maua mo etahi tuahuatanga, Penei i te wa kua tae te haere ki runga i te maara kai . Ko to maua nei Papa tera, i te whakatupatotia i a maua, i te tohutohu i a maua. Aaa koina tetehi, aa i te wa o te marama e pera ana maua, tino kaha ana ia ki te korero atu ki a maua Kia kaua e maua e haere ki reira, ki te kohikohi kai , te hutihuti, whatiwhati nga hua rakau aa hua whenua pea, ano hoki kia kore maua e haere i runga i nga hoiho, aa ko ia tera ki te kaukau ko to maua nei paapa tera. Engari i mua i to maua nei pakeketanga, ko to maua nei mama i te tohutohu i a maua me to maua nei tuakana.

He rerekee ta te koka e tohutohu ana i a raua tamahine, e rereke ano ta te tuakana.He mea ngahau ki aku tuakana,e pera. Etahi wa ka huri mai ki te whakatumutumu i a maua, ka ahua mataku maua ka pera ai ka haere atu ki to maua nei koka.

Ko ta tera ahuatanga te whakatupato maua he rereke ano, ka huri mai ano, i te mea, he kaupapa kino, ki te tamariki. He kaupapa kaore ano te tamariki, e marama ana ki tera tuahuatanga. Noreira ko to maua nei koka, e ata korero mai, e ata tohutohu mai i a maua mo tera ahuatanga. aa Ka tae ki te wa ka pakeke maua, ka titiro ki te tane, ka pera ka ahua kino atu maua, ka mea atu maua kaua e korero pena,e porangi ena korero, ko te tamariki tera ne kaore i te tino mohio ki era tuahuatanga.A tona wa ka pa mai ki a maua. Heoi ano ko o matou nei matua nei, i te tohutohu i a matou, no te haerenga maitanga ki konei ki nga kura teitei, penei ki te whare wananga ki te kura akoranga mo nga kaiako, era taputapu o te pakeha .Ka papaoho era ahuatanga ki a reira, i kite ahau i nga pukapuka pakeha e Te Peehi, mo tana haeretanga ki roto i a Tuhoe, ka kite e au i etahi o ana korero i mau i ahau.i te wa e noho ana ia i roto I a ratou noreira ka kite e au i era whakaaro na te Maori na te pakeha i whakaheemi ki roto pukapuka .Ano hoki etahi korero kei runga te pouaka whakaata, me era taputapu o te pakeha, ka papaoho atu me era tuahuatanga ki a tatou i roto i o maua kainga engari ko taaku tino aawangawanga ki aku mokopuna i te mea ko nga pikitia kei runga i te pouaka whakaata, me te rorohiko hoki, he kino, e takahi ana i te ataahuatanga o te tinana, ne Kei ro tahataha katoa nga whakaaturanga .mo tenei mea . nga ahuatanga i waenganui te tane me te wahine , kua huri kuri ke nga tuahuatanga me kii. Koi ra taku awangawanga, tetehi o aku tino awangawanga, na wai ra ka haeremai ratou mo nga hararei, kei raro tonu e penei ana, he aha tena e matakitaki ana e koutou, kao he mea rawa tera he kino rawa wera whakaahua kaati aa huri atu ki tetahi atu teihana ana ra ke nga mea e tikane, ko au tonu kei te tohutohu i a ratou.maua tahi.

Korua ko to hoa?

Ae, me to ratou tipuna koroua. Ae engari e mohio ana ratou, anei te taumata, kaua e noho ki raro nei kei ro tahataha ke era. Nga mea e kite ana ratou i runga i te pouaka me nga pikitia i nga toa, e ahei ana ratou ki te haere ki te hokohoko ki te tango, ka haere atu au ki o ratou taha, ka ki kao, kao, kao, kao.

Pera I te Pent House ne?

Ae ae tenei whare he whare pera, he whare mo wera tuahuatanga e ki he whare tapu, he whaere tapu, tapu katoa e era tuaahuatanga. Noreira kua mohio ratou kao, ka rahuitia era mea kotoa kaua e mauria mai ki konei, waiho atu ki nga wahi e pirangi nei era tangata.ki te haere.

I te wa o to tamarikitanga, i te taha o o koka, tipuna whaea, kaore enei tumomo pikitia i taua wa ne?
Ae, ae, tika tonu ko te mea i te wa i au i roto i taku tai tamarikitanga, ko te mea ko te serials, ne ia wenerei. I tipu atu au I Ruatoria e toru nga po mo te pikitia ko te Wenerei te Paraire, ko te Hatarei. Ka haere ahau ki te taha o tetehi o aku tungaane, he tuakana tera, ae ka piri atu au ki a ia me tana whaiaipo Ka haere au, ko te serial ko Peyton Place. Ki o matou matua, tino kino tera serial, engari ki a matou he mea hei wero ki a matou no te mea ko wai o matou e kaha ki te haere ki te matakitaki i a Peyton Place. Noreira ka tapiri atu au ki taku tuakana me tana whaiaipo, ka haere au ki kitea etehi o era serials ne. Koia te mea o taua wa, ano hoki ko te pukapuka i roto i te Truth ko te Truth he pukapuka kino , he nupepa tera, i taua wa anei ko to taua papa i ki kaua tera pukapuka i mauria mai ki roto i tenei whare Anei ke nga pukapuka hei panuitanga mo koutou, ko Te Phantom Te Mandrake ko te Girls Chrystal ,ko te School Friend hei panuitanga mo matou.me aku karanga me nga mea e hakinakina English Soccer. Koia anake nga pukapuka mo matou. Era me nga comics o Disney, Donald Duck.
Engari mo te truth, koia ra te kura ki Manutahi Koia ra te kura Maori tera o Ruatoria o matou e kura ana ki reira. Ko etehi o aku hoa kei a ratou tetehi kape o te Truth ka hui matou ki te wharepaku, ki reira matou e panui ana nga korero o te Truth, me nga whakaahua o nga mea kua oo aue, Mehemea ka rongo mai o matou maatua, ka karawhiuwhiu o matou nei whero,o matou waewae, ana to kai. Ko te ketuketu ki a maua, Kaua e panui era pukapuka, he paruparu he kino wera pukapuka..

He aha te take ki a ratou tenei kino o tenei paruparu na te aha ai ?
Ko nga korero, i te mea ra i roto i aua pukapuka, ko etahi whakaahua mo nga wahine kei te mau i nga kakahu kaore i te pai ki nga pakeke.He mea ra ko nga u o te wahine tatania ka makere mai ki waho, kei raro nei e ai ai, tetahi atu o nga kakahu kaukau, he bikini wean. I to matou wa, kotahi tonu te kakahu, me wera mea Nga whakaaturanga a te pakeha ne, me nga korero penei. Kua wehe a mea raua ko mea, kua divoce mea, aa ko te kite nga panui o te pepa ra ko wai kei te mahi taane, ko wera nga kino katoa. Ka panuihia i roto i tera pukapuka kaore e tika ana ma te tamariki e panui.

Ki o ratou whakaakoranga ki a koe i runga i te ahuatanga mo enei, ko te mea i roto i to tupuranga, e tapu te wahine, he tapu te tane?
Ka hoki aku whakaaro mehemea ka wanangahia i o ratou mahi ki a matou I taua wa he ahua tohutohu i a matou hei aria atu i a matou I wera tuahuatanga i ahu mai I te ao pakeha. Ki te mea ki a a ratou he mea kino. He whakaaro noaiho tenei. Noreira ki ahau nei, he momo tohutohu i a matou tera.

He aha o ratou whakaaro ki tenei mea te takataapui, te moe tane ki te tane ,te moe wahine ki te wahine.
I te kareti o Ngata ahau i taua wa, tetahi o matou nei, he wahine rongonui nei, ooo he tau he toa ki roto i nga mahi te tito waiata hakahaka, koia tera. Ka tito e ia i tetahi o ana waiata ka mauria mai ki a matou, ki tera takiwa o Ngati Porou ne. Ka akona matou, i aua waiata mahi a ringa. Engari ko tana ahua, aha koa tona ahua kakahu rite tonu ki to te taane te ahua, Tarau roa, koti, e mau nei nga taane i aua wa ,,pootai aua pootai, me tana ahua, me ana ahuatanga katoa kai paipa, rite tonu ki to te taane, engari mohio tonu matou, he wahine. Engari koira tana ahua, te mau kakahu taane, ahakoa haere ana ki whea. Haeremai ki matou, hoki atu ki Tokomaru aa ko taua ahua ra, engari kaore matou i whakahawea, ka rereke te titiro ki a ia. Mohio tonu matou, ko Nanny tera kei te pai, kei te haeremai i roto i tana tarau ,tangari , tarau roa aa ona kakahu katoa, nga kakahu o te taane ne ae.. Engari kaore ana matou e whakaaro eee, Ki a matou, ko to matou tupuna tera. kei te pai, haeremai, haere atu aa wera e pai o ratou whakaaro ne?Ae,Ae na te mea he whanaunga. Kaore matou e titiro whaiti penei i. Te hoiho kei te oma me ona blinkers kei runga. E haermai, he whanaunga, noreira, ko wai au hei kii,oo kua rereke te ahua o nan kei te mau kaka tane ke…., kaore ana matou i whakaaro pena Me nga mea i tipu mai i o matou nei taha. Whakaaro ana matou oo ko o matou sissies ena.Koina te ingoa i whakamahia matou, he sissie a mea a mea a mea..Engari kaore he raruraru ko matou matou, nga whanau e noho nei i taua wa i Ruaoria. Haere katoa matou ki te kura me nga mea ahua pakeke, i te ahua pera ko taua ahua Kaore matou titiro ko nga taha e whakahawea e korero parahako, mo ratou kao. ko matou matou.

Ko enei ra, he rereke rawa ne te ahuatanga ki a ratou taupatupatu enei mea rereke i etehi nga takataapui?
I a .maua e noho nei i te puku o te taone o tamaki (Mount Fogell tenei wahi.), i mahi ahau i te wahi o te tolls.Tekau tau e mahi ana I reira Ka kite ahau ka tutaki nga takataapui I reira. Katahi ano ahau ka kite i te takataapui .kaore ano ahau ka mea, aaa nei ano etahi atu sissies ka pai. Engari he pakeke wenei atu enei pera i nga mea o te kainga.oo Tino hoahoa matou I te mea, he rawa ke a ratou I nga kakahu a katahi ano au ka kite i a ratou e cross dress, ana koia te kupu.ko era tuahuatanga, me nga ahuatanga korero, noho Ka haeremai ki roto i a matou, ka huihui katahi matou ka haere ki nga kanikani. I te wahi e mahi nei ahau, rite tonu matou nga po whakangahau, kanikani socials ne. A ko matou katoa ka haere koia ra o matou nei hoa nga

sissies nei.. oohe rawe ka tiaki ko ahau.Mehemea kaha rawa te unuunu kaha rawa te parakaraka ko ratou kei te tiaki i a matou whakarerea katoa e matou engari pai o matou nei tane ki a ratou , i te mea kua tino mohio nei matou ki a matou.
Patai

Ki o whakaaro he aha te putake ki tenei wehewehe o enei whanau ki a tatou .Ki etahi atu he mea kino ratou. .
Tuatahi tera pea era whaakaaro i haeremai i te pakeha, te taenga mai o nga hahi, nga momo hahi ki ahau nei Mea nei ka whakaaro koe, kei te whakaaro au mo nga mo nga whanau e pera ana te ahua, e kaha ana tenei ahua i roto i a ratou i te kainga i Ngati Porou. Te nuinga i nga kainga Takutai, i te taha o te moana ne. He aha ai? Koia ra nga wahi tuatahi i whakatutungia nga taone i te Te Tai Rawhiti, Te Araroa haeremai penei ki Tikapa, Waipiro, Whare Ponga, Tokomaru nga wahi i reira, kia watea pea nga kai puke te haeremai ki te tiki nga wuuru, te mau mai nga rawa mo nga toa pea. Ki taku whakaaro koira pea tetehi o nga take, i te mea wetahi o nga whanau i ahu mai i reira, o nga hapu i te taha moana .Ko nga pakeha i haere ai ki kona ki te whakatutungia o ratou toa ki reira. Ki taku mohio tera pea i roto tonu i a tatou i mua i te haeremai o te pakeha ki konei ki Aotearoa nei. Koia ra te mate. Kaore nga pakeke I korero ana ki ena take. He aha te kiko o era korero, ne, he aha te kiko.Mehemea ,engari no naiano nei, i enei tau kua tahaatu nei,10, 20 tau pea . ko tetehi wahanga o taku thesis mo taku takutatanga kua timata tonu au ki te toro atu ki toku nei reianga. Matou i timata i te kura o Ngata, i te tau tuatahi, kua korero mai etahi ki ahau , kaore ratou e tino pirangi ki te hoki atu ki Ruatoria. Ki o ratou kainga, ki o ratou whanau, kei reira tonu e noho ana, no te mea, nga mahi tukino i a ratou, i roto tonu i te whanau. Noreira whakaaro au, e hika tera pea, i roto i a tatou pea i roto tonu i a tatou whanau Maori wera tuahuatanga timata au ki te raparapa haere e hoki atu ki nga tuhituhi ,nga korero kei te korero an mo nga, i roto i o matou nei whakapapa i te Tairawhiti. Hei aha e nui nga korero o te papa ki tana tamahine, me ki, ki ana mokopuna hoki. ae Kua kite au i era tuhituhi Ka whakaaro au, hika ma katahi te mea rereke (kei te whakaaro tonu au tera ea i roto i a tatou pea
Ka moe te matua i tana iramotu me tana mokopuna, Kua taangia era korero. Koia taku pai ki oku matua, ki toku koka, meatia au, hey, ko o taua nei tupuna i kite e au.
i roto nga whakapapa,i moe a mea i a mea, i moe a mea i a mea ka puta mai ko mea , o taua nei tupuna. Ka mea mai taku mama ki ahau, koi ra tonu nga mahi o nga tupuna hei pupuri i te mana whenua. Kia kore e puta atu te whenua ki iwi ke. Koira ki te pakeha kua tau mai ki roto i a matou o Ngati Porou

E tikanga kua tipu ake ki etehi. whakaaro i waenganui whakapapa.
ae Koia ra oku nei whakaaro, hei pupuri te mana whenua ne, kia kore e putaatu ki waho. Koina tetehi o aua whakaaro i aua wa, hohou i te rongo, koia, te take ka whakamoea nga wahine o Ngati Porou ki wetahi atu iwi pena i a Whakatohea, Kahungunu tera pea koira tetahi take engari, i roto ano i nga mahi a whanau tera pea i reira tonu tera tuahuatanga. Na koina pea etahi o nga wahine i huri pera Te wahine ki te wahine, me to ratou mohio. eii i mutunga mo ratou, ma te koroua ra ke, he wahine ma te koroua ra.Engari ki ata titiro tatou tera pea, ka kite tatou wetahi korero kua whakamarama te ahuatanga.

He aha o whakaaro i te wa e taupatupatu te wahine, ko etehiii i haere atu ki era wahi?
I roto i a matou o Ngati Porou ,kei te marama matou,i tera pito o Ngati Porou, ki
te Raki, Te araroa, Whetumatarau. Te haeretanga a Nga Puhi, Pomare ma, ki roto i a matou, Ka mauheretia wetehi o a matou nei tupuna, kuia, pera i a Te Rangi Paea, ka tae atu ki Te Taitokerau ka noho atu ki reira, me wera tuahuatanga.Kei te marama matou ki wera.Te ingoa o taku mama, ko tana ingoa ko Te-Iwi-Ka-Raru, he ingoa na oku kuia i tapa ki runga i aia, hei maumaharatanga mo tera parekura me ki,.o tera mamae nui ki a ratou kia kore matou nga uri e wareware ne, koi ano ra.

He aha o whakaaro mo nga rongoa mo ene ii tukino o te ao nei?
Korero te tika, kaua wetehi atu, kaua e hunaia koia ra te mea.. E mohio ana au i te wa e au he puhi tonu ana, ka pakeke au i runga te kore mohio, ko wai nga whanaunga e tata ana ki ahau. Hoiano, ka haere te wa, ka ahua raru ahau. Ka mea mai taku mama ki ahau, hika ko korua korua,ko to tungaane tera. Taku, ae, kaore au i mohio, i te mea kaore ratou i tino whakamarama nga whakapapa, tu atu nei i oku nei matua tipuna ne? Kaore i korerohia, Mehemea ka titiro ki i te taha ki tana papa, i te mea. ko taku kuia, te mama o taku koka, nana matou i poipoi i roto i Ngati Porou.Ka wareware ki te taha o taku tipuna koroua, me tona taha ne. Ka riro ko te kuia nei, katoa ki te whakatipu i a matou.

Kihai ratou i te korero ko wai koe, ko wai era atu?
No to matou tipuna kuia. Mohio tonu matou engari te taha e pa anaki to tatou kuia ne, te koka o toku koka, kaore ratou i korero i te mea ko taku tupuna koroua i haeremai i roto i taku kuia ne. Ana ka noho tonu ko to matou tipuna kuia te mea uuu, ka Ehara i te mea ka wareware, engari he mea, i runga i to matou kuia, te mana whenua,wera mea.Na wai ra i riro ki to matou nei ti puna kuia te mana o taku nei koka, nga mea katoa ko taku Ngati Poroutanga, ahu mai i taku kuia.

He aha o whakaaro mo nga rangatah nga taiohi o naianei, he aha nga tumomo rongoa he ako i a ratou.

Taku me kii ai ra mo aku, a maua nei tamariki ,toko toru ratou, toko ono nga mokopuna mai i a ratou. ko maua tonu kei te tohutohu i a ratou .Kaore e tika ma etehi atu ratou e whangai ki enei tuahuatanga ne? Koi ra ke te mate, i te wa i a matou e tai tamariki ana i te wa kainga, kaore aku, ka korero atu mo toku koka, mo tenei mea, ka pakeke haere te kotiro ne, a tona wa ka titiro atu hika.he tane te mea ra,Ka ahua titiro, ka titiro , ka titiro ne.Ka rongo koe tetehi atu ahuatanga, oo he pai tonu te tane, kaore koe i te tino mohio, he aha te take e pera o whakaaro, ai kaore e.Ka kii mai taku mama ki au, kaua e piri atu ki te tane, ka whanau pepi koe.Kaore te tika te korero ne, te tohutohutia i a matou kei te tiro noaiho au ki te mea ra , ki e tangata ra ki te taitama ra. Kaore au i te whakatata atu ki a ia ,ka titiro noaiho,kaore au e hapu, ka korero pera kaore he korero,engari mehemea, ka aata nohongia matou, anei ki te moe koe ki te taha o te tane, i te whakamarama matou ki te whakamarama, ka matau ,engari kua mohio ke matou, i te mea ko o matou nei tuakana ana kei te whakamarama mai ki a matou.anei, ka penei, ka pera, ka haere koe ki te taha o te tane, ka haere pera korua ka haere pera etahi atu,kaore e roa ka hapu koe. Kaore ratou tee tino whakamarama he aha te !!!!! me pehea te ra te hapu, he aha hoki, koira noiho. !!! Mehemea ka korero pera kia marama matou , he aha te take e hapu koe aa, pai noa ki..,.Koira aku korero ki aku tamaahine, i te wa i tae raua ki tera pakeketanga, i whakamohio nei raua , anei, anei, anei.kaore korua te haere ki te kura i runga nei, ka haere korua ki te kura mo nga kotiro anake. i te mea kotahi tonu te kaupapa kei runga i a korua, anei nga whakamatautau, School C ,UE Bursary, ka haere korua ki te Whare Wananga.Engari na koina aku tohutohu i a raua.

Kei te mohio koutou i roto i te whare nei ki te tiaki tamariki tiaki mokopuna me pehea nga huarahi pai mo nga rangatahi, mo nga taiohi iroto i te kurai mena he tukino te ahuatanga o ratou nei matua.?
He rawe naianei i roto i nga kura, kua hoki au ki roto i te kra hei kaiako.
Kua kite e au, kua tu kei te kura o Pakaranga. Kei kona au I tenei wa. Kei reira nga Counsellors mo nga tumomo ahuatanga e pa mai mo nga taiohi., me nga whakatupuranga e korero nei tatou ,noreira mehemea he ,!! Nga tumomo raru kei roto i te whare, ka pa atu ki aua tama tane ama wahine kei reira, kaore wera taumaha e utaina ki runga i a matou nga kaiako.Ka haere ratou ki te counsellor ne.Tetahi kei reira he wahine Maori.noreira pai noaiho. He tokomaha tonu a matou taiohi kei te haere pera, kei te haere pera ki te korero. Koia ra te mea e maatau ana ki nga ahuatanga penei mo nga mahi nei te peka, kua pakeke nga kotiro nei , nga taitamariki, kua wahine ratou ,ki taku mohio kua rongo ratou. i te reka o te tane, te reka o te wahine me kii ,kua rongo ke ratou, me titiro tonu ki a ratou e ta, kua mohio ke ratou i roto i o ratou korero, te ahua whakakakahu i a ratou , nga mea e whaka kakara kei a ratou katoa e mau ana.ae nga korero mo te mate wahine kei te mohio katoa e nga tane kaore he mea tapu. Ko nga tauira Maori wenei. He ngawari noaiho ki a ratou ki te whakaputa i roto i te akomanga i mua i ahau, kaore ratou e whakaaro he pakeke tenei te kaiako kaua e korero wena korero Kaore he tapu He wahi ano, he wa ano mo ena korero no te mea he korero rere rung ahau ae, kua pera te ahua o nga tauira i roto i nga kura tuarua, kua kitera. He rereke nga tauira o tenei kura, i te mea te nuinga he pakeha he tauiwi. i au i te wharekura i Mangere, aue tino kino te matau o wera ki nga ahuatanga katoa.

I roto i te whare kura?
Ae Ae. Mohio ana ratou. Ka korero mai ki a koe, ka wero atu koe, he aha to whakaaro mo tena mo tera? E hika ma, ka mau te wehi mo wena tamariki, tino kino te mohio, He mohio i te mea, kua kitea e ratou i era, i oku nei whakaaro, kua kitea e ratou i era tuahuatanga i roto i o ratou kainga.

Kei te ako haere i nga ahuatanga Maori i rotoo Te ao, i te whare kura? Ko te ao turoa nei e tino maro ke?

Ae ae tino matau ana ratou i etehi tima, ko au ke te tino whakama.Ko au ki roto o taku kuiatanga Ka noho ma nga tamariki nei, he mokopuna wetehi ki ahau, *Ko ratou te pouako*? Ko au te pouako Ko ratou kei te kawea i nga ahuatanga o te ao whanui ne, Ka tino whakama au i te mea te hohonutanga o to ratou mohio ki era tuahutanga.

He aha te Huarahi kia whakatika i enei tuahuatanga?
Kei o ratou matua tonu Engari kei te mohio ana tatou ko nga matua o naianei he rereke ki nga matua o to taua reianga, i kite mai taua,i te mea i tipu mai ake au i roto i oku matua tipuna i te wa kainga.ne.Ko te rongoa mo nga taitamariki nei ko te whakaako ma te nuinga o ratou, kua kore o ratou nei tipuna konei e noho ana.I whati mai ratou i konei , e hia whakatupuranga kei konei e noho ana., e toru pea.Kua huri kua rereke ratou kaore he mea hei kume i a ratou , hei tau i a ratou ki te wa kainga ki nga ki era o nga whanaunga kei reira e noho ana.

Ngaro te reo ngaro te whakapapa.
Ngaro to ratou ao Maori ki a ratou ne.Kua whai o ratou nei matua tera pea ko nga tupuna pea i whanau mai i konei ka mutu te pakanga ne me hoki atu ki wera tau . Ka mutu te pakanga i tera tau wha tekau ma rima i tera rau tau i wetahi , e mohio nei ahau i etahi o aku papa ka hoki mai i te pakanga ka tau mai te tima ki konei nga waipuke ki Tamaki nei nga tareina ranei, ka noho ki konei i roto i nga iwi o konei pakeha Maori Ka noho mai ki konei ka whanau noa mai nga whakatupuranga tahi, rua,

toru pea ana kei konei e noho ana, kua motu te taura ne? Ki te wa kaingas ki to ratou kahui whakapapa Kua kore ratou e mohio ki tera ao, i ahu mai i ratou nei tupuna ne?Kua huri pakeha katoa to ratou ahuatanga,te hinengaro, te wairua na me pehea e totika.nei? Ina, hoki atu tatou katoa ki te wa kainga, tera pea, kei reira pea tetehi rongoa. Engari kei konei au, ka tae ki toku nei wa, a kia hoki au ki te kainga, ka kaha au ki te kumea aku mokopuna kia hoki atu ki te Tai Rawhiti, kei reira pea ta ratou tutakitanga, putakitanga, kei te wa kainga kaore i konei, he manuhiri ahau ki konei.kei te noho noiho , i runga i a Ngati Whatua muri mai i a taua. Kei te mohio au ki ter, Koina nga korero i rongomai i aku taringa. Ki mai i aku pakeke,kaua e wareware kei te haere noiho koutou ki te rapu oranga, kia pakeke koutou, kua matemate ke matou, a kua timata ke te ngarongaro haere, a tena, hokimai, hei whka ili mai nga whawharua. Koia tonu nga korero mahue mai ki a matou nei i te kainga.Kei te marama matou

Koira te raru ki a koe inaianei ne? Kua wehe atu ratou i te ao Maori, noreira me pehea?
Ae kua motu te taura kaore ra ratou i mauria mai ki to ratou nei po. Engari ko taku patai ki nga tamariki nei , i te wa i ahau i nga kura tuatahi he kaiako ana, ko wai o *penei* ***te whakautu*** **, ko wai o koutou matua tupuna?** ***Aua***
Mehemea mea kei roto i te wharekura ratou
Ae i nga kura tutahi Hauraki i nga kura tuatahi,e hia nga tau, ahau e ako ana, koira taku atai kia a ratou *No whea koe*? *Ko wai o maatua*? Ka pera .Kei te pera noa akuanei. Ka patai atu au ki nga tauira kitea noa au i o ratou ingoa, uuu he ingoa no Te Tai Rawhiti, maatua , ka ki, *A ko wai o tipuna? Ooo* Not sure*. Ko te whakautu I'm not sure*.

I roto i nga Kura Hauraaki me nga whare kura penei?
Ae, ae, me te whare kura hoki, Kaua koutou e whakaaro kei te pumau tonu nga ahuatanga o te ao Maori i roto i nga wharekura, i te mea, mo etehi o nga matua, he wahi tera, hei mau i o ratou tamariki, makere atu ki reira waiho atu ki reira. Mai i te ata ki te ahiahi.
E pera hoki etehi o nga matua,no te mea kei te rere tonu aku patai Ko wai o iwi, ko wai o tupuna? Kaore e mohio, ko te reo kei te korero i te reo engari ko te reo kei te rere i runga i te hau , kaore he mea hei tapiri atu ratou ki te whenua ne. Kaore he mea pera. Ka aroha atu,aroha atu

Kaore he Tikanga i roto i te reo ne? He reo noaiho?
Ae, he reo noaiho, kaore he mea, kua kite ahau i tera ahuatanga i te wa i whakatungia nga Kura Kaupapa Maori i konei. Kei te korero au mo te tau waru tekau ma iwa,i whawhai pakanga matou ki te kawenata, i tu te hui ki Poneke, kia tu ai nga kura tauira ne (e ono nga kura) I taua wa te kura kaupapa Maori o Waipareira au i taua wa. Ko taku hoa e mahi ana i te Tari Maori o Otara nei. Ka whakatika mai te iwi o taua whenua ra, Haere,Kia tere to haere ki te whawhai i te tahuhu kia tungia te kura kaupapa mo Otara .I reira au e kura mahita i roto i te kura reo rua Ka haere matou ki te pakanga atu ki nga mea, ki nga pakeha me ki aa ka riro Waimarie matou ka whakatungia he kura kaupapa mo Otara. Ko nga tauira tino kino te mohio,te matatau ki nga ahuatanga waenganui te tane me te wahine, nga tikanga kino kaore e tika ana kia mohio nei ratou. oooo tino mataku au i te mea ka penei

Ana ki a koe na ratou i kite ki roto i te kaingai tenei tuahuatnga.?
AA, ki whea hoki, ki runga i te pouaka i roto i nga mahi kei te mahi i roto i nga kainga.Mohio ratou ki te kai tarutaru, me wetahi, whakarongo tonu koe ki wetahi o ratou korero, nga mahi waenganui te wahine me te taane, kua kitea ratou kua mohio ratou, ngawari noaiho ki a ratou te whakapuaki i a ratou i mua i ahau i roto i te akomanga , koi ra ooo ka tangi hotu ahau Koina te mutunga mo tatou, i whawhai matou mo enei tumomo kura.Ko tenei te hua ,kia tika ra kia tika ra.

He mahi tino uaua mo te taone tino nui rawa penei ?
Whakangarongaro ratou i nga taone penei i te kauta te nui me ki. E hara ratou, te ahuua o te whanau i roto i nga taone nui penei i Akarana nei, kua rereke, he rereke tonu te ahua o te whanau Maori i roto i wenei tumomo taone. He rereke to maua nei whanau i te mea, ko maua tonu, ko te putahi ki tahi, ka moe mai e maua, mohio maua ki a maua, timata maua i te ra tuatahi ki te kura o Manutahi, timata maua i reira, ka tipu ake maua ki te kareti o Ngata, ka haeremai maua ki konei, ko tana ki te whare wananga, ko au ki Ardmore. Engari i haeremai he whaiaipo maua mai i te wa kainga,
Ka moe maua, ka puta mai nga maua tamariki, mokopuna, ko maua tonu kei te tohutohu i a ratou ki te pupuri ratou hei whanau ne. Te ahua whakatipu i a ratou, e ahua i tipu aim aua i te wa kainga, i roto nei i o maua matua, tipuna, whanaunga, te whanuitanga o tenei mea, te whanau,te hapu, te iwi, pera i roto i nga awaawa o nga tipuna. I aua wa kei te pera tonu maua ki te whakatupu i a maua tamariki. Ki ahau nei, kaore tetehi tangata mo te haeremai ki roto i to maua nei whare, ki te tohutohu i a ratou i roto i enei tuahuatanga, i a ratou e puta atu, ko au., Kei te pirangi ahau he aha nga korero e whangaihia ki a ratou e paana ki tenei kaupapa, kia mohio nei au. Mena ka rongo korero au,aa kei te pera (smack) tika tonu taku haere atu ki te kura, aa he aha tenei mea na. Kaore au e whakaae, ko au to ratou kaitiaki ne? Ko taku mahi he kaitiaki, kia paitia taku tiaki,

rangatira taku tiaki i aku tamariki aku mokopuna Nawai hoki, kaore au whakae ma wetehi atu e tohutohu i roto i weneii, hohonu wenei tuahuatanga ne? Noreira kei a maua to maua nei rangatiratanga i roto i nga ahuatanga katoa e pa ana ki a ratou.

Ma wai, aa ma te aha ka whakatika, i etehi atu whanau?
Koia ra te mate, kei tena whanau, kei tena whanau, huri noa, huri noa, huri noa ne/ I roto i te reo pakeh ame kii, devolve koira te mea. Na tatou tonu i whoatu tera ne ki te kura koira. Kei reira te raru. Hokimai ki te whanau, engari kia mohio te whanau, he aha te taonga ku makaea e ratou ki te kura. Kaore ratou i te mohio, kei nga whanau tonu te rongoa hei whakatikatika whakahokia. Tikina to rangatiratanga, whakahokia mai ki a roto i a koe, kainga, i to whare, kia noho rangatira ai koutou, nga matua ki o ratou nei , nga matua whanau, tamariki mokopuna kia pera..

He Kaikorero No Taranaki

Ko ena i a koe i korero mai na mo tama tane na ka hoki ati i te timatanga o Toi Te Taiao, ne, ka hoki ra me te wahi ngaro, te wahi una, te ku teretere matua te kore heke iho heke iho heke, ka tatu te rarangi o nga korero… te rarangi o nga korero mo te … hei harawa taku korero ra… tae mai ki tenei wa

Pupuke te hihiri, pupuke te mahara, pupuke te wananga, wananga nui a te kore, heke iho hele iho heke iho, na tatu atu ko hautapu, ko haumua, ora ki te whakatipua ora ki te whakatawhito, heke iho heke iho heke iho, ana ka tatu rawa, ko Rangi raua ko Papa, ko Tama-nui te Ra, ko Papatuanuku tera, ne, na ka puta, kona nga atua o te po o te ao marama, heke iho heke iho heke iho ki te tai ao e tu ake kei mua tonu i a tatou kei o tatou ringaringa e pupuru ake ana i te tai ao, nga ahuatanga o te tai ao , ko enei te mea e ki ai, ko te a, ko te o, ko te ao o te ao marama, na kei roto i ana ringaringa he pupuru ana kei roto tonu i a ia te o, kei konei te a, he oti ano te tatou, e titiro ake, he whakamate ake, he whakaaro ake, heke tapu he tapu he tapu, ko te tapu tenei o nga atua o te po o te ao marama, na ka heke iho heke iho heke iho, na, ka puta ko rongo tautangata matua, ko Tane, ko Tumatauenga, ko Tanganroa, Haumietiketike, Tawhirimatea, me era atu ano, ko Ruaumoko, ko Whiro, ko Hine-ahu-one, te takapau whariki e nohongia i a tane, ne, na ka heke mai i reira ana ka puta mai nga uri, na, ko Tane ki a Hine-ahu-one ana ko Hine-titama ana ko enei te rarangi whakapapa e taka mai nei, e heke mai nei ki a tatou.

Tane ki Hine-Titama, ana, ko Hine-a-Rangi, heke iho heke iho heke iho, na tona mutunga, ka tatu ki… kia tama ki te ao marama. Ko enei ko a tangata ka puta ko tama tane ko tama wahine ko tama ariki, e mohiotia nei i a tatou he tamariki, engari, te timatanga mai ko tama ariki te matamua te mata hia po e noho tono ai tera hei matamua no tena karangatanga whanau, na mai i te ara tae mai ki tenei wai ko taua kaupapa ra mai ano i aua korero i tatai a mai i roto i nga whakapapa ki a tatou i tenei ra tonu nei E noho tahi ai tenei mea te tangata i roto i ona Tikanga, ko te reo, ko te mana, ko te whakaaro, ko te tika me te pono te Maramatanga, na te mea kei roto i nga ahuatanga o te tapu o te noa, engari, kia tatou, kia marama tatou, ko tama wahine, tama tane, he tapu he tapu he tapu ka noho tahi ka hono kei te mohio ano he tapu, engari, ka tai a enei ahuatanga i roto i te wahanga o te noa, engari ka haere atu ki roto nga wahi tapu ma te karakia ka uru atu ma te karakia ka puta mai na te mea no roto i enei ahuatanga ana ko nga kei roto i nga karakia, hei oioi haere ma tatu kei reira katoa nga korero kua korero o tatou matua o tatou tupuna i te wahi a ratou, ue, koira i kawe ai ki konei, i roto i te kauae runga me te kauae raro, ko enei te whare wananga o te ao Maori, ka haere to tohunga, ka haere te tangata ana kei te haere hoki tana whare wananga me nga Maramatanga oro e tika ana kua mohio kua marama i runga i te korero ki te hunga tamariki i runga i ou tatou marae kia oti a runga, kia oti a raro, ka puta e koe ki waho mo te patai a mai koe i waho ra nga patai, ne marama katoa ana kia mohio te tamariki, te tamaiti e puta ra e wero ra nei, a, he patai tika ra nei, ka kore ia mohio ka kore ia taea ki te whakahoki atu te patai e hoki atu ai te wero ki te kaikorero nana patai, enei ahuatanga kua tae mai inaianei ki te kaupapa e korerotia ake nei te hononga o tama tane o tama wahine kia raua i runga i te kaupapa te tapu me te whare tangata na kei roto i enei ahuatanga, he wahanga ano kei reira, e tu ake ana to mana o tenei mea o te hikakatanga, ne, te hokakatanga o te tangata, ko te hikaka kei konei, ko te hokaka kei kora engari, ka tete mai nga niho o te hokakatanga, ana kia tupato, kia tika, kia marama. Ko matou kuia, e korero ana e tama ma tiakina te ure, tiakina te ure, kaua e parati noa iho, engari, tiakina te ure, kei roto hoki i te whakapapa ra, kia tika to aratika i to whakapapa, kei koti, na, ko enei te ahuatanga kua tae mai tatou, na, kia marama hoki tatou, kei roto i te tapu, kei roto i te mana kei roto i te ahuatanga o te matauranga e mohio ai tatou e marama ai tatou kia tika kia pono, mahia te mahi i runga i te tika i te pono na, engari, ko te ahuatanga o nei patai, na te mea, kaore tatou i te tino mohio, mehemea kei runga i te tika i te pono ranei tatou e haere ana ka tirohia ake ia ra ia ra, he patu tangata he patu tamariki, he patu wahine e nga mea katoa kei te haere i waenganui a tatou. He aha ra wai pera, ne, he ara ra wai pera, na te ngaro, o te ahuatanga, o te tapu, o te tika, o te pono, o te Maramatanga, na, hei timatanga korero pea tenei i to patai, na, me tuku atu ano pea kia koe e patai hei wetewete mai etahi o nga korero he porangi…

Nga korero i rongoa i oku tauheke, kaore i rere ke atu ko matou tonu ko ratou tono ko tatou tonu tera. He momo tangata he ahuatanga tangata, he aria te kararehe, he aria to weriweri, he tangata, no reira manaakitia te tangata, a, ko enei nga korero i rongoa i au i te wa ki au, na, i mohio au ki te hunga i korero ana korerotia nei oku kuia tauhere, te hanga o aua tangata i roto ano a matou i te marae i te kainga e mahi ana i nga mahi e marama ana e tika ana kia ratou me te kite atu e hanga ano ta ratou he maramatanga he tohungatanga ano kei a ratou, na, ko enei taku e whakahoki atu to patai, ne. Kaore i rereke ki a tatou. Kaore i porangi at penei me i ahau, ae, me he porangitanga ana kei te porangi katoa tatou, engari, he wa ano ka tau tawa korero ra ki runga i te taraka, ne, na, engari mo te takataapui kaore kau he rereketanga, no te whanau he karanga tangata no roto i tera whanau no roto ano i a tatou manaakitia.

Ae, me pena te korero. Ae, ko ora te ahua te whakaaro o te ao tawhito, te ao tawhito i … Konei au ki te whitu tekau tau na, ka rongo atu i a ratou, e, ono tekau tau pea te rongo nga ena korero, na kua rereke tera ao i tenei ao, kua rereke nga nekenekehanga a te tangata i tenei wa i tera wa, na, ko enei nga ahuatanga e… ai tenei kaupapa i roto i a tatou pehea te whakahaere, pehea te kawe, pehea te whakamaru, te whakamau i nga taumahatanga i a mamae e pa mai ana ki tena ki tena ki tena, ae. Tera wa, e tamariki ana e toro te mahi marama ana au te haere mai tatou ki te tau kai te mahi nga mara i era mahi katoa, ne, he miraka kau, he aruaru, he waiwai, tikaokao, he te pahi i nga upoko o te tikaokao, ana, ka matakitaki atu kei te oma haere te tikaokao, kaore he upoko, na, enei ra, kaore ano au kia patua tikaokao, kaore he raruraru pera… haere ki te toa kei reira he tau mai ana nga tikaokao kua mate maoa. Kaore he mate tonu kai inaianei, haere ki reira, kua maoa mai te kai ko enei nga rereketanga i tera wa.

Ka rereke katoa nga whakaaro o te tangata na te mea e nui ana tatou kaore i tupu mai i roto i te reo, kaore i rongo i te reo, kaore i rongo i nga korero i haere ain a, kua tae mai au ki tenei wa i tieke ki te whitu tekau tau, whitu tekau ma whitu tau na, kua rongorongo au i nga mamae te wae i nga Kaumatua, ki te atu… taku waewae…ana, kua rongo au i aua mea ra ana, kua kata noa iho ki au…ki taua tau mate i mama era taku tau heka,…ana kua pera, na te kete na te rongo kua marama, ne, engari ka kore e kite i nga korero i nga ahuatanga tera wa e kore marama ki nga ahuatanga ka tau mai ki runga i a tatou. Ko nga ahuatanga o naianei, ko a tatou tamariki ka kite ko te mohio ratou ka heke ratou ki oku tau marama tuturu ratou ki a ratou e no tenei ao ke tatou.

Ko enei ra te mea i te kukume mai i nga ahuatanga i kawea ai i te reo i te wahi a ratou, ko te reo te kai kawe i nga korero i nga Tikanga, i nga ahuatanga katoa. Hei whakatikatika i te tangata, he rongo te reo, he mana te reo, he Tikanga te reo, he matauranga te reo, na, ko era te mea, te kohanga reo, te kura kaupapa, te whare kura, a, kura mata noi tatu ki nga taumata o te whare wananga o te ao Maori. Kaore au e ki a whare wananga a tauiwi, kao, he rereke nga whare wananga o tauiwi. Engari, ko te whare wananga o te ao Maori mai i te kauae runga ki te kauae raro, ko enei te hononga o te tangata mai i nga kuia au heke iho ki nga tamariki mokopuna nga uri wai muri ake ko enei te kaupapa matauranga Maori, kaore hoki te kawanatanga e aro mai ki te tuku i te matauranga te kaupapa matauranga Maori ki te ao Maori, kaore ratou e aro ki te tuku me noho tonu ko ratou hei pupuru i te kaupapa o te matauranga, a, ko wai roto i o ratou kuwaretanga, kore mohio nei ki te korero tena koe, a, te aroha mai i roto tana korero, a, ki te whakaua tonu i te ingoa o te tangata Maori kia tika, kaore he arowana ki tenei ao, no reira, he aha tatou i tuku ai te kaupapa matauranga i te kawanatanga, kua tae ki te wa unuhia mai e tatou katoa o nga waka, o nga maunga, o nga rohe a iwi me te ki, kati rawa o kore tika mai te kaupapa matauranga mo te hauoranga mo te matauranga mo te ohaoha era ahi katoa ahu whenua, ahu moana, ahu te ao, ma te Maori ano tera e whahaheke, e tika ai i runga i te whakapapa, i whakapapa rangia mai tukunga mai i a tatou tae mai nei ki tenei wa.

E Tikanga e, mai ra ano nga Tikanga mai ra ano nga Tikanga i roto i te tapu e marama ai ki te tapu ki tenei wa, na, ena mea katoa me hoki mai kia tatou hei whakarite, engari ko tatou tonu e tuku ana i te Tikanga ki muri, kua hoki atu tatou ki o tatou marae, a, haere atu tatou i runga i te Tikanga o te marae. Engari, etahi o tatou marae ka ahua rereke nga Tikanga a ko ano i runga i te marae, kua rereke. He wa ano, e kua kore he kuia hei karanga, na, ena ahuatanga ne, na te mea kua memeha, ne, kua memeha te waiora o te marae o te kainga o te hapu o te iwi, kua pera, kua kumea ki taone nui ki taone roa. Ko taone tiketike enei traumata o tenei wa, ne, na, kei reira te nuinga o te ao Maori kei roto i nga papa taone nei ne, kaore i runga i o tatou papakainga. No reira kei roto tatou i te, i nga awaawa e haere ana kia taraiwa ano ki nga taone, ana, kua hihana o tatou mata kua tae mai nga tiramarama ne, ki reira i nga nekenekehanga o te taone nui, ana, kua hiki katoa o tatou ngakau, na kua kamakama te haere, kapai, hoki atu ki te marae. E kaore mahi o reira, kaore he tiramarama o reira, kua rereke te noho engari, mehemea he kaupapa o te kohanga reo, te kura kaupapa, whare kura wahai a mahia hikitia hapaia whakanuitia korerotia waihangatia katoa tena mea engari kia hora pakoki te whenua, ka kaore ora pai i te whenua, a, ka noho raruraru tatou a muri ake nei, engari, kia kaha to tatou titiro, ma wai tatou e whakahaere ma tatou ano, ma tatou ano, ma tatou ano, ma te ao Maori e whakatakoto kaupapa mona mo te matauranga, a, ko ano mo te hauoranga, a, ko ano mo te Tikanga, na, te mea, Tikanga hoki to tatou i te wa i mua kaore ratou i tae mai ki konei, na, i a hatia ae e tatou, kaore tatou i te kukume mai hei wero atu i atu. Taihoa, taihoa he Tikanga ano tama, he Tikanga ano kei konei, he Tikanga puta mai i te tapu o nga atua o te po, o te ao

marama, na, i korerotia ai i o tatou tupuna i runga i o tatou marae whakatakotoria ai nga korero hei herenga i te tangata, ki ona marae. Ana, i korerotia ai tenei mea te kawa tapu te kawa tapu, ne, he Tikanga, he kawa, na nga atua o te po, o te ao marama, marama ai o tatou pupuru, ne, te moana, te wai, te moana Tangaroa, te ngahere, te whenua ena ahua tangata ka tuha, me te mohio ano te taenga mai ki konei i marama ratou, mua o te urunga mai ki te whenua, me korero ano ki nga atua, ana, kua noho ratou ki te korero ki nga atua o te tae ao o tae mai nei ratou, ne, i mua o te haerenga ki roto, na, ko era te uruuru, te uruuru whenua, ana, na te karakia na. ka tuku koe i to tinana hei kai ma nga atua, ma wea kai tenei manuao, ana, korero koe nga atua,…, te tikina mai ki te kai i a koe, tuara kua ngenge i te tu, tena pea kei te pai, kei te tautoko na mai nga atua , na, mihi atu i roto i to karakia, ka u ka u ki tae, ka u ka u ki uta, ka u ka u ki tenei tauira ki tenei whenua tau hou, ana, ena korero katoa, e ono ae te wairua o te ngakau o te tangata ki te whenua hou me nga atua o tenei whenua na, ko era te hononga atu e marama ko te tapu o te whenua, ne. Na, engari ma te Tikanga ka uru atu, ko te Tikanga ko te karakia, ma te karakia, kauru atu ki roto me kapohia mai… tangata ra i tana ke, haere mai, e kore te tira e noho, kua haere ke, engari kaore i pera, na, ko ena. Ka tae mai tatou ki konei, na, kei konei tohu.

Me penei taku korero, me rongo nga tamariki i nga korero i korerotia ai nga Kaumatua i te wa te nui ana te Kaumatua, ko era hoki te reo. Ko era hoki to ratou reo, no reira he uautanga tenei ki te whangai i te tamariki ki enei korero, ki rongo hoki o ratou me te kite o te kori o te tinana o te aha ranei o te tinana o nga mata te ahuatanga o aua korero, ne, kei te ako noa iho o tatou kei te ako penei i te kuware, ne, te tamariki ra whanau mai ki tenei ao, kaore i te whanau kuware mai, kua rongo ke i te ao i ai a i te wai kaukau ana i roto i tana puna, ne. kei te rongo katoa, na te mea, te putanga o nga uri a Rangi raua ko Papa, ana, kua rongo tau tangata matua te tuatahi, na. kei roto i era korero i whakamarama ana te ahuatanga o rongo tau tangata matua. Kua timata ke te rongo te tinana o te tangata kei to rongo nga wahanga katoa i te ao e tu ake ne, na, engari kua ngaro te hohohutanga nga korero o rongo, ne, o rongo, he korero ano te whakarongo areare ake o taringa te whakarongorongo mai nein a, mea engari he rongo ano mo rongo tau tangata kia tau tike te tae ao, kia tau tike te tangata, kia tau tika te ahuatanga o te tangata, i roto i tona hinengaro, tona ngakau, i tona tinana, i tona mauri, tona mauri tau tika, na, ka ora a ia ka kore tau tika tona mauri, na, he aha te raru, ko te mea ka kimi i te rongoa, ka haere ki te rapu i te rongoa, i te ngahere pea i nga tohunga i nga Kaumatua e marama a nei a, na te mea, e mohio ana te tangata ma to ngakau ka ora te nuinga o nga ahuatanga ia a koe, na, ko enei nga mea hei whakahokia tatou tamariki, he uaua, he uaua, engari. Ko ena te mea e to tika ae tatou a muri ake nei. Ahakoa he reo tahi he reo rua, waia atu o roto o taua reo i nga Tikanga o reira kia tika kia pono kia marama he tapu. Ahakoa, he reo ke, engari ko te reo tuturu o te ao Maori e hono ae ki te tae ao. Ko tona ake reo i mua o te taenga mai o tauiwi me ana kaupapa, ne, nui tonu nga kaupapa a tauiwi i haere mai kaore i haere mai ki konei. Hei painga mo tatou, kaore i haere mai i konei. Hei manaaki ia tatou i haere mai ke ki nga rawa ki nga painga ki nga waioranga o te ao Maori, te whenua, te ngahere, te moana ena mea katoa. Te whakarangatiratanga i a ratou, kaore, i haere mai ki te manaaki i a tatou, kaore i kite i ahuatanga i reira e tae ai i te noho tahi i a tatou, kaore i heke, kaore e pirangi tena, kua oti ke ta ratou i mua o te haerenga mai, kua rua rau tau e nana ana ratou ki te kapokapo i te muru i nga whenua o te ao, ka tatou ka mea mutunga. Ko tatou nga mea mutunga i kore ai no to tatou haerenga mai, engari, kaore e tatou i mohio i pera ati a nga iwi o era whenua o te ao o roto Amerika. Amerika ki te tonga, Amerika ki te raki, puta noa hoki atu Te Moana-Nui-a-Kiwa, murua kahutia.

Te Pa Harakeke O Te Tangata[203]

"Hutia o te rito o te harakeke
Kei whea te komako e Pa
Mau e ki mai ki a au
He aha te mea pai?
Maku e ki atu ki a koe
He tangata, he tangata, te mea pai"
(Te Meringaroto -Te Aupouri)

Anei tena whakamarama i roto i te reo o Tauiwi:
"If you pluck out the shoots of the flax plant
Where will the bellbird find nourishment
You tell me what is the most important thing
I will tell you
It is People!

203 The following extract is quoted from the Bioethics Council website. Written by Kaa Williams, it explains Maori views of birth and whanau.

It is People!"

Hei whakamarama ka huri ake ki te tino ngako o enei korero.
Ka huri ake ki te kaupapa o te rawekeweke putau i waenganui i te tangata, i te kararehe me te putaiao.
Kei roto i tenei whakatauikii e whakaritea ana te rito o te harakeke ki te whanau o te tangata. Ko te rito te wahanga kei waenganui i te harakeke. E rua nga rau e whakamaru ana i te rau hou e pihi ake ana i te pa o te harakeke. Ko te tipu hou tenei, ko te pepi. Ko nga rau whakamaru, ko te whaea me te matua. I te hutia enei rau, i te tukinohia ranei, e kore e tipu te harakeke, na te mea kua taongohia tena putake, kua haumate te kakano i whakatongia i te timatanga.
Ka penei ano te ahua mo te tangata. I te tukinohia tona ira, me ona putau kua kore e tipu tika te tamaiti i runga i tona kawai here tangata, ahakoa te korero "He kakano ia i ruia mai i Rangiatea, e kore e ngaro".
Ko tona orokohanga i heke mai i nga Atua, i te wa i whakahokia mai e Tane te ira tangata, mai i Rangiatea, mai i a Io Matua Kore. Ka heke tenei ira ki tena whakatupuranga, i roto i ona kawai whakaheke, a tae noa mai ki te tangata o tenei wa. Ki te ringa-rawekehia tona ira, ona putau, ko wai ka mohio he aha te momo tangata ka whanau mai. Koinei te tino awangawanga, me te mataku o te Maori ki tenei tiahua. Kua pakaru te ira whakaheke o te whanau. Kua uru atu he ahuatanga rereke noa atu.
Kua whati ko nga tikanga. Kua kore e taea te mihi ki ona mate, ki ona tipuna, i roto i nga mihimihi, poroporoaki ki te hunga mate, i roto i nga whaikorero, na te mea, kua uru atu he putau tauhou ki roto i tona tinana, kua tau he wairua rereke.
No reira, mehemea ka tapahia te rito o te harakeke, mehemea ka whakarerekehia te ira tangata, ka raru ko te toi tipu o te rakau me te toi o te tangata i rahuitia e Io-Matua i te Hono-i-wairua.
"Taku tamaiti, e, i puta mai raa koe i te toi kai Hawaiki.
He toi tupu, he toi ora, he toi i ahua mai i Hawaiki"
(Williams,(S.ii, 51))

Te Whakapapa:

Kei ia tangata tena ake whakapapa, ona taura here, mai i ona matua tipuna. I heke mai i te murau o te mano, i te wenerau o te tini, i nga whakatipuranga maha o ona matua tipuna, a, tae noa mai ki a ia. Kare e taea te whakawehe atu i a ia i runga i enei ahuatanga. Ko te whakapaparanga tenei o tona ake ira tangata, o tona ake wairua, o tona ake mauri. I roto i nga whaikorero ka mihia, ka tangihia enei tipuna, ka whakahokia mai ki te aoturoa mo tetahi wa poto.
Mehemea ka whakataruwekutia tenei ira whakaheke e te ware, ka tapahia te taura here o tenei kawai tangata. I heke mai enei karapinepine i nga Atua, hei whakatiti i te taha wairua ki roto i tona whakapapa. E ai ki te korero:
"He taura taonga e motu,
He taura tangata e kore e motu"
(Best 1975c:45)

Te Ira Tangata:

Koinei te ahua e pa ana ki te kunenga mai o te tangata i roto i te ahuru mowai, a, tae noa ki te wa ka whanau mai ia.
I tenei wa ka hono tona wairua me tona tinana hei oranga ngakau, hei pikinga wairua. Ka uru ki roto i a ia te Hiringa-matua, te Hiringa-tipua, me te Hiringa-tawhitorangi. Ka karapinepinehia te putoto ki roto i te whare tangata ka whakawhetuhia ia i mua i tona putanga ki te aoturoa.
I tenei wa ka noho tapu ia. Ka pera ano tena whaea. Enei ira kei roto i a ia. Ka noho pumau tonu. Ka hoki ki te korero, kotahi tonu te hiringa i kake ai a Tane ki Tikitiki-o-rangi, ko te whakawhiwhi ki te Hiringa-i-te-mahara, mai i a Io-matua-te-kore. Ka turuturu i konei te Hiringa matua me te Hiringa taketake ki te ao marama, ka waiho hei ara mo te tini e whakarauika nei. Ko tena mauri, ko tena wehi, ko tena iho matua, ko tena ihi whatumanawa, ko tena hinengaro, ko tena ngakau, ko tena pumanawa, ko tena auahatanga enei, ka whakatungia.
I te pokaina, i te rawekewekehia, i te whakawairangihia, ka kore te whakaaro e pupu ake i roto i te tangata. Ka noho wairangi noa ia ka kore he matauranga.
Ko te whakatauki i waiho mai, e kii ana:
"He kakano i ruia mai i Rangiatea
E kore ia e ngaro."
(Te Aho Matua: s155 Ed. Act, 1989)

Te Whanaungatanga, Te Matemateaone, Te Manaaki, Te Tiaki, Te Atawhai:

He ahuatanga tino nui enei me puea ake i roto i te tangata Maori.

Ka tipu te pu harakeke, ka tipu ano te pa harakeke o te whanau, o te hapu, o te iwi. I te piripono, i te kaha te whanau ki te mau pu tonu ki ona uri, ki ona kawai here tangata, ka tipu te matemateaone ki waenganui i a ratau. Ka manaaki, ka whakamaru, ka tiaki tetahi i tetahi. Ka whakaatu i te wairua whakanui, whakaiti ranei ki mua i te aroaro o te tangata. Ka whangaihia te tangata ahakoa ko wai. Ka atawhaitia, ka whakamahanatia.
He tikanga nui tonu enei. I tenei wa o te ao hurihuri, ko te tangihanga noa iho kei te kaha ki te pupuri i nga ture me nga kawa o te ao tawhito kia whakamahia tonu. He mahi nui, he mahi uaua i runga i nga huringa o te noho i roto i tenei ao.

He rahi nga aukatinga me nga whakatu taiepa kei mua i o tatau aroaro. Ko enei, ka hahau tonu mai i te ahuatanga o te whakawhanaungatanga. Kia kaha tatau ki te awhi i te whanau. Ara te korero:
"E kore e ngaro,
He takere waka nui"
(Ihaka 1958:22.42)

Te Wairua, Mauri, Tapu:

I te orokohanga mai o te tangata, he tinana tona, he wairua tona. I te ao Maori, he wairua to nga mea katoa, to te whenua, to te moana, to nga tipu, to nga kararehe, to nga manu me nga momo ahuatanga katoa o te ao.
Kei ia taonga tona ake mauri, tona ake tapu, me tona ake ahua. I heke mai enei ahua i nga Atua.
Ka whawhahia enei e nga kaimahi putaiao, i runga i a ratau mahi nanakia, ka weteweteki na tetahi o nga miro, o te werewere takai i te wairua me te tinana ka puare te tukutuku. Kaore e roa, ka papahoro te whare. Ka patua ko te tinana, ka patua ano ko te wairua. Ko enei taonga me orite tonu te noho tahi i nga wa katoa.
Ko te mauri te ngao o te tangata. I heke mai ano tenei ahua i a Io- Matua- Kore. Koinei te ha-ora, o nga mea katoa. Ko te mauri te kaiwhakapumau te kaihere, te kaihonohono i te wairua me te tinana.
Ka mate te tangata, ka mate ano tona Mauri.
Kei roto enei tikanga i te ao wairua me te ao kikokiko. Ka pa he raru ki te tinana, ka pa ano te raru ki te wairua. Ko te katoa o te tinana ka raru.
Ko te tapu na te tangata ake i whakatau, a, mana ano e whakamahi. Ka tukuna e ia tetahi ahua ki raro i te maru o nga Atua, kia kore ai e taea e te tangata te takakino. Ka hoatu he mana ki runga i taua ahua. Ehara te tapu i te ahua kitea e te tangata, engari kei nga wahi katoa, tae noa mai ki tenei ra. He ahua hei manaaki, hei whakatupato, hei atawhai, hei tiaki i nga taonga, me ki o te taiao, o te aoturoa, o te putaiao. He maru mo te tangata i roto i ēnei ao.
Koinei te tikanga kei te tukitukihia mai e nga kaimahi putaiao. Kaore ratau i te märama ki tenei te hua o te whakataputapu i te taiao.
Kei te ki etahi, he aukati noa iho i a ratau mahi rangahau i etahi painga i etahi rongoa mo nga iwi katoa. Kei te ki etahi o ratau, he mahi whakapohehe noa iho i te whakaaro o te tangata, na te mea, kaore he kiko e kitea atu i roto. Heoi ano kei konei tonu te tikanga o te tapu.
Ko te tangata te mea tino tapu rawa atu. Ona toto, he tapu. Ona makawe, he tapu. Tona tinana katoa, he tapu. Ka mate ia, kei te noho tapu tonu tona tinana.

Te Mana:

Ka huri ake ki te tikanga o te mana. E wha nga mana nui o te tangata.
Ko töna mana Atua:
I ahu mai i runga i te tikanga tapu o te Ahi Komau.
Ko töna mana Tüpuna:
I heke mai i runga i ona Kawai Ariki, i te rangatiratanga o nga tipuna, i nga taura here o ona matua tipuna. Na ratau tenei mana i whakatau ki runga i te tangata.
Ko tona mana Whenua:
Kei te whenua te mana ki te whakatipu i nga momo ahuatanga katoa. Mai i te timatanga o te ao marama, ka whakatungia e nga Atua te mana whakatipu kai ki te whenua hai homai oranga ki te whanau, ki te hapu, ki te iwi hoki.

Tera ka whanau mai te pepi, ka whakahokia tona whenua ki roto i a Papa-Tua-Nuku hai whakatupu mai ano i te oranga ki te tangata.
Ehara na te tangata te whenua, engari na te whenua te tangata.

Ko Tona Mana Tangata:

Ka heke mai tenei ahua i runga i tona whakaatu mai i tona toa ki te mahi i tetahi mahi. I heke mai pea tenei ahua i roto i ona ira, mai i ona tipuna, nona tonu ranei te kaha ki te whai i te mahi kia puta, kia whiwhi matauranga ai ia.
Mehemea he kaha te wahine ki te manaaki manuhiri, ka rere tona rongo ki nga topito o te ao. Ka haere ano tona rongo, mehemea he manutioriori ia ki te karanga i runga i te marae. Tae atu ki tona rongonui ki te tito waiata. Ara, a Tuini Ngawai, a Mihi-ki-te-Kapua, a Timoti Karetu, nga toki mo tenei mahi.
Ara atu, ara atu te maha o te tangata ka uhia te mana nui ki runga i a ratau.
Na te whakauru putau, ira hou ki roto i a ratau i penei ai na runga ranei i nga ira tangata o o ratau matua tipuna?.
Ki a au, no ona whakapapa ake tenei mana. He mana whakaheke ka tipu i runga i ona mahi i te mata o te whenua.
Kei te taha o enei mana ko te ahuatanga o te Kaitiaki. Ko nga tikanga o tenei kupu ka pa ano ki te manaaki, ki te tiaki, ki te atawhai, ki te tawharau i te whenua, i te tangata, i te taiao. He kaitiaki hai mahi i nga mahi, hai whakatau i nga tikanga kia pumau, hai tohu i te ara pai, hai pupuri i te mana o tona ahua, o tona ahua kia piripono tonu ki a ia ake.
I roto i te ao Maori, e toru pea nga ao whakapaparanga o te tangata.
Ko te ao o nga Atua;
Ko te ao o te Tangata;
Ko te ao o te Mate.
Ko nga kaitiaki ka noho i roto i enei ao he wairua, he tipua, he tipuna, he kararehe, he manu, he kitenga ataata, he wairua tangata.
I te aoturoa o nga Atua ka noho ko nga Whatukura tane, ko nga Mareikura wahine hai kaitiaki mo te toi o nga rangi. Ko nga Apakura mo nga rangi o raro. Ko nga Poutiriao mo nga ao e toru o te Tangata.
I a ratau te mana ki te whakataurite i nga kare o roto, i nga whakaaro, i nga momo wairua katoa o te ao o te tangata. I te tukinohia tetahi ahua, ka kore e whaimana enei kaitiaki ki te whakatau i te mauri ki roto i a ia.
I te aoturoa o te tangata he rahi nga tuahua o nga kaitiaki. He taniwha, he ruru, he tuna, he kuri he manu, he kararehe, he mokomoko, he ika, he poraka, he rakau, he wairua tangata. Enei ahua katoa, he kaitiaki. Ko te tirohanga a te Maori ki enei ahua, he tirohanga a-wairua, engari, ko nga hua ka puta, he hanga tangata. He whakapono tenei ki nga aheinga o te ao wairua e taea te whakawhiti mai ki te ao kikokiko. Ka wawahia enei whakapono, ka raru ko nga mahara.
I te ao o te Mate, ko Hine-Nui-Te-Po te kaitiaki. Mana e tauawhi te hunga kua pahemo atu ki te Po. Ahakoa kua tanumia te tinana o te tangata ka noho tapu tonu, me te whakapono ka whakawhiti atu ia mai i te mate ki te ora. Koinei te take ka ka rangirangi te whakaaro i nga mahi poka noa a nga takuta me nga kaimahi putaiao.
No reira, ahakoa ka taea te kitea atu o nga painga ka puta mai i roto i a ratau mahi torotoro me te rangahau i nga momo ahuatanga o te aoturoa, kei roto tonu i a au u te awangawanga, te maharahara, me te ponana mo enei mahi takakino.
Kei te tino kaha toku whakapono ki nga tikanga, ki nga ture me te wairua o toku ao onamata me ona ahuatanga katoa. Kei te whakapono au ki te mana o te whakapapa o te tangata, ki tona ira tangata, ki tona wairua, ki tona mauri me tona tapu. Ko ona mana e kore e taea te whakamawehe me te takatakahi. I orokohangahia mai te tangata i te ao nehenehe kia noho piri te wairua me te tinana o te tangata, kia kore ai e rereke tona ahua, tona waiaro, tona pumanawa me tona auahatanga. Kia rongo kau i te tangi o tona ao Maori tuturu.
Ka mutu ake nga korero mo tenei wa i runga i te whakatauki a koro ma e ki ana
"He riri ano ta te tawa uho,
He riri ano ta te tawa Para."

MAORI SEXUAL AND REPRODUCTIVE HEALTH WORKERS

PART FOUR A

Kaupapa Maori

This section brings together interview comments on kaupapa Maori. There are three broad categories that people discussed kaupapa Maori in:
- deconstructing western notions of sexual and reproductive health
- critical analysis of sexual and reproductive health for whanau
- what does kaupapa Maori look like?

Deconstructing Western Notions

In terms of the western constructs they're all up for grabs really in terms of being pulled apart and analysed and repositioned but you know the other thing is that you just throw them all to the side and begin. There are changes in attitudes to sexuality and body parts. There have been a number of issues that have impacted on Maori ways of dealing with sexuality. With colonisation came the medicalisation of the body and secondly the influence of fundamentalist Christianity, then morality – filthy and moral panic. New issues have emerged since the 1980s with feminism. Pakeha analysis of sexuality has predominantly been through either feminism or through glbt/queer analysis. Both assume the primacy of individual rights, both miss the context of whanau. Both also assume that world views are the same for all individuals. Both assume that power relations are understood through gender and sexual identity but not through colonial destabilisation and through race/ethnicity. Land and environment and a sense of mana and tapu are all key aspects to Maori sexual wellbeing.

Whakapapa
It was pointed out that sexual knowledge and sexual identity differed for everyone.
And, your sexual and reproductive health also has to do with whanau, hapu and iwi really. That kind of like safety at that level is an interesting concept. I haven't really thought about that a hell of a lot. But, just having discussions last week about things like tono, and.., you know, and why.., yeah, whether you sleep with or choose to have babies with who, for what reasons, bloodlines stuff and all of that comes into it. So, as Maori that's part of our sexual and reproductive health and wellbeing. That kind of knowledge. Which is not that hard to reclaim but, it's something we need to reclaim.

There are debates around who is further ahead:
I think we're probably further ahead in terms of the boys stuff because, they've had more issues around you know, HIV and Aids has been more prevalent and more talked about in terms of gay boys stuff. The research is fairly emergent I guess, for lesbian families around HIV Aids.

I don't know about boxing ourselves into those identities anymore, even as takataapui. I guess there are certain risks to consider that are more associated with being takataapui than heterosexual especially, for boys. But.., we've got to be careful there because we're now, I think, in a time where people are a lot more fluid with their sexuality and so, we've got.., as Maori I think, we've got to be careful about boxing off and targeting sexual and reproductive health issues within those identities. I think, we're much better to just look at what are the issues for Maori, and make sure that we're covering the spectrum of sexuality but, that is us. Because, you know, there are heaps of people nowadays that swing between you know, gay and straight relationships all the time.

Sexual health is not separate from the wider issues of Maori health.
Sexual health is shouldn't be actually, separated out from the rest of your health and wellbeing because, we're not sexual beings at this time of our lives and nonsexual beings at this time. We are everything all of the time. Yeah, so it's having a bit more of a holistic view. Having said that, it's easy to have that holistic view once you've gained some kind of specialised knowledge, in particular areas, aye? Then you can kind of apply it broadly.

Reductionism
Well, it's a reductionist thing around how you're meant., aye? How you can define yourself, who gets to define who you are and how you are. It's like the adoption stuff, you know? We don't require adoption, because we have whangai. I just think it's for you to be idealistic and that.., if you're going to be that across the board. But, don't be doing that only around same-sex issues, and then go and vote for that Bill on dogs and shit you know?

Anyway but, that's going to throw up a whole lot of stuff too around.., Well the whole thing around the sexual and reproductive health stuff is that someone came on and talked about the whole thing of we have whangai we should be returning to matua whangai and doing that. Which is fine, I think, if it's going to be a legislated maintained thing where you actually have some rights around that. But, it still comes back to the same old nuclear family argument and that's where Tariana mucks up. She doesn't actually realise that her argument when you track it back comes back to a really western framework because, the whakapapa kaupapa frameworks that we would have had in place are not in place. So, what happens to those children? I mean that's my thing. What will happen to this baby if we can't adopt her? And, that's what we should be concerned about if we're concerned about whakapapa.

Whangai is an inherent part of sexual and reproductive health and should be talked about in sexual and reproductive health programmes
So, then all the korero around whakapapa in terms of sexual and reproductive health you know, there's a whole lot of things in there. And, it's like Taakirirangi writing about whangai and whakapapa and how we do that, and when do you whangai. Because, whangai is inherent to sexual and reproductive health for Maori. It's an inherent part of our roles and obligations, and relationships.
So, if you're a whangai what are your other rights as a person within that whangai whanau, hapu, iwi? And, his basic.., I mean his argument is really clear. You have all those rights as part of your inherent.., you know, being in that whakapapa line as whangai.

In sexual and reproductive health programmes do they talk about whangai? I mean because that should be a part of a sexual and reproductive health programme. We shouldn't assume that everyone is actually sexually and reproductive capable, you know what I mean? You know, there's an assumption in that. Is actually that we all are able to reproduce.

Takataapui

When you argue for a separate voice e.g for takataapui you run the risk of being marginalised. This is an important debate within the takataapui community.
I suppose it's like do we actually want to see that as a separate voice? Or, is it actually more important to stop ourselves being marginalised. To make sure that we're also talking about other things otherwise, we run the risk as academics, of being put on the margins and not actually listened to. I tend to think that's a risk that we run, you know? If we want to be heard and stuff then we've got to keep on doing stuff that is particular to us as takataapui but, make sure we've got enough other stuff in which to contextualise it. And, if we're doing things in a Maori way that's what we'll be doing anyway.

The history of Homosexual Law Reform in the 1980s saw the emergence of a stronger political stance by Maori and pakeha. But Maori had their own identity and expressed it through developing the label takataapui. The history of this battle needs to be told. (Some Maori think that the term takataapui only refers to gay Maori men)
Well, the political times are different too. I mean the reasons for that staunch identity as takataapui was gay or lesbian peoples. It's born from way earlier but, my memory of the 80's and the Homosexual Law Reform Bill and stuff like that. If people weren't staunchly out then and staunch to, 'I'm lesbian and that's it.' Right through. You don't swing, you don't flip from one to the other. You know, Homosexual Law Reform would never have got passed actually if there weren't people that were that staunch. Now we're still.., you know those people are in their what? I don't know, late thirties, forties, fifties, and sixties now. So, there's still that era of people who will stay staunch to that way of being because of their political.., yeah, developments. But, now there's a whole younger group coming through too. And, some of us who are just.., I guess, move with the politics of our time, who are challenging that, and saying well you know to do that is actually to do ourselves disservice. And, it is. It's interesting how the politics have shaped our sexual beings and therefore our.., the way that we need to approach sexual and reproductive health.

Whanau rights and individual rights work together. Sexuality for Maori isn't just about individual rights but is also shaped by ideas of the health of children and knowledge of whakapapa. Our ways of doing things in the past such as tono are important to reflect on and to reclaim
Well, I guess we're responsible to ourselves first and fore most, for our own health and wellbeing. But, it's broader than that in that, I think what I was talking about before was.., you know, who we choose to have children with, how we make those decisions, and what the broader implications are in terms of our bloodlines, and where our own whanau and hapu would like to see that progressing. So, it's important, for me, that part of our sexual and reproductive health knowledge is around protecting and nurturing the whanau and hapu that we come from. And, so part of that is who we choose to sleep with, have babies with

or, whangai with. You know, and there's lots of.., it's about.., part of it's about knowing.., you know in the past we had many instances of tono, and we still have those as well. And, part of that's around ensuring the ongoing.., what do you call it? You know, validity and wellness of our bloodlines.

There are practicalities to consider if forming relationships within your own iwi or a nearby iwi.
But, it's also practical stuff as well, and that's something that I hadn't thought about until recently. But, you know, when you choose to parent with somebody, you're better to choose, on a practical level someone from a neighbouring iwi or whatever because, simply put, if you are going to split up for example as I am, you know how many hours away from my own iwi because I chosen to parent a child with someone from an iwi that's miles and miles away from my own. So, it presents real problems, aye? When you want to move back home. Even if as a couple you know, you're staying together but, you've still got those problems about if you move back to so and so's hapu or iwi then you're miles and miles away from the other one.

Whanau Vs Individual

Whanau rights can supercede individuals.

> *Yeah, I think in relation to.., certainly to whangai and to adoption and stuff, guardianship, all of those things and family court.., Yeah, the rights of whanau may certainly supersede the rights of the mother of that child. For example if you were to go to court over custody and stuff or, over your living arrangements once you split then, it might be because the child already has existing relationships with whanau in the other partners tribal area.., then the.., although she might be the primary caregiver, may not be allowed to return to her own home with that baby just because of the broader whanau rights. So, there are.., yeah, our law does often supersede the rights of the individual.*

There are barriers and constraints to Maori accessing information about STI's. Unless they directly know someone or have whanau with the problem it's hard to relate information as Maori educators, health workers and audiences respond to peoples direct connection or personal experience of an issue.
Access to knowledge around sexual health - I was talking with some people last week who were saying that in relation to HIV and Aids, unless you have somebody within your own whanau who's affected directly by that it's really difficult to access that information. We access the information based on personal experience, and experience within your own direct whanau. It's hard to relate to others around STIs and blood born viruses unless you've had personal experience. Because you kind of share no knowledge on it otherwise. You've really got to go and seek it out.

For pakeha much of the emancipation around sexual liberation has been about talking about masturbation and explicit sexual practises or body parts.

Spirituality is connected to sexuality. It is argued here that we need to know our atua for us to know our own sexuality.

> *I suppose, that for me as a wahine Maori, that my sexuality is not divorced from my spirituality. And so, if I'm not spiritually well and spiritually knowing then I can't connect to my sexual wellness to that, if I can't then, I'm not going to be well. Sexually or in any other way. So, sexual and reproductive health for a wahine Maori is about knowing who you are as a wahine Maori which, is connecting to your whakapapa, tatai whakapapa, you know, ko Rangi, ko Papa, all of those kaitiaki, all of those Atua are part of our health and wellbeing generally. So, they're not divorced from our sexual and reproductive health either. So, we view ourselves, our bodies in the way we use our bodies, play with our bodies, be ourselves in whatever way we are, is connected to them and what they tell us ourselves are about. Yeah. So, to know, for me, as wahine Maori to know my kaitiaki, my Atua, is to know my whakapapa, is to know my whanau, is to know myself. And, then if I know all of those things I will be well within that. Yes. Yeah, yeah. And, if you have that knowledge about yourself then you are much less likely to go out and.., fuck everything in sight or, behave in ways that are going to put that.., yourself at risk. Because, if you're putting yourself at risk then you're putting your whakapapa at risk, if you like.*

But, having said that, that's also what should tell us how to have fun with, and how to be with ourselves. So, it's not just.., having that knowledge of who you are isn't about wrapping yourself in cotton wool and making sure that you're a little angel or whatever. It's also about learning how to be and how to have fun because, if you know yourself that well then you're that much more confident and you know what your boundaries are, you can push them right to the limits, and have fun with that. Yeah in whatever you do.

Kaupapa Maori for one person also affected who they choose as partners

Well, if you just think of kaupapa Maori as being Maori then it relates in every way. So.., you know, I am Maori, so therefore however I think about whatever I do is a Maori way of thinking about it. So.., kaupapa Maori for me is not divorced from any part of the way that I live my life. Yeah. So, what difference does it make? It's a tricky question now because, being Maori is such an intrinsic part of who I am. It's interesting to kind of deconstruct and think, 'Well what does it mean?'

I suppose it's why.., you know, in our political context now, it's probably why I'd never choose to sleep, I don't think with a white woman or a man. Things like that, you know? So it's.., being aware of.., being conscious of our political context and stuff like that affects who and how you are with people. Yeah. How you choose to behave and stuff like that. Yeah, yeah. Who you relate to and how and where. Ha, ha. Yeah. Yeah.

Pukorero

I do believe that it is, that the interpretation, or even in some ways the ignoring of those stories and the devaluing of them as childrens stories, fantasies, legends, mythology, which is really another way of saying they are not really worth knowing. Only one book, there was really only one story. And we actually haven't moved on from that. I mean Western society has in the last 100 years, questioned the Christian imperatives and they have revisited that in light of things like science, things like, I don't know, environment, etc. Pakeha's have gone out of their way to rewrite Pakeha society from that monopoly of Christianity. They've gone and done it.

We need to try to be more critical and critically talk our stories through.
Yes, we need to not just reclaim our stories, not just reclaim them, and say lets publish them again, because no-one would know what the hell they're talking about.
I think the ideas of having forums with some key cultural analysts and people that can critique and ask as many questions as offer answers, is good. And it's just creating a form of debate, and making suggestions of what that could mean, what are the implications of that. Like the one you and I were discussing, why a sneeze, why not a fart, why not a burp, why not a wink a blink, why not a snort? What sort of significance, are we missing the sinificance of it? Because we're not identifying what could've been. I think the subject matter is so important. We virtually have nothing. We have nothing.

Personal Learning

What emerges in peoples personal experiences is the lack of information or education within whanau. For Maori there is a lack of discussion – either traditional korero or information on sexual health in the current times.
It was really mainly mates, good friends, kind of just talking with each other and finding out what we could find out. With my sisters it was more stuff around what happens when you bleed, you know? So, when you had your first period.., Because my mother said really stupid things to me around bleeding. Things like, 'You can't use tampons because you only use tampons when you've had a baby.' You know? "Why? I don't understand what that means." Yeah, but my sisters mainly told me but, predominantly mates you know? Just around school. I can't even think formally in my school short of biology at high school, and that was really kind of very much about the physical makeup and.., you know. There wasn't any formal classes around I think that relationship stuff with mates is really what happens or, what happened for me. In terms of.., and it was really general.

There is a lack of information to adults unless you go researching yourself. If you don't have research skills you miss out or can be misinformed.
I think there's a lot of public stuff. I mean if I thought about even now, what is there available publicly that would inform me.., Unless I went looking for it there wouldn't actually be anything really. There's nothing kind of dedicated in radio, and nothing dedicated in television.., assuming there's probably still programmes and pamphlets and stuff. I would actually have to go looking for the information so I mean that's problematic actually.

When I think about that now there's actually nothing that's kind of right there.., you know there, available, unless you've got almost like a research skill to go and find it. So, how do people find it if they don't operate the way we operate which, is actually.., I mean there's all the online stuff, there's heaps of that. People on-line and even then you've still got to be able to dig through the stuff to get a good understanding of what there is there.

Education

Maori need access to sexual and reproductive health information as adults.
See even now, I don't think, I mean.., yeah, we've been looking at different things around fertility stuff and we've had to really seek it out. We've had the clinic people who've been really great at providing information but, if your not attached to something like that it's either in books or there's a lot.., there's a lot of on-line stuff around fertility issues but, you've got to really.., like there's just so much it's almost like an information overload. So, if you can't be really clear, and you can lots of also wrong information, you know online so, you have to be really clear about what you're looking for and how to find it.

See even that, I mean that's a clear path in terms of sexual and reproductive health material but, even at this point we're really having to dig around and find out, and be quite clear with the specialists and stuff, you know? About what we want to know and how we want to know about it, and give our context.., because they make a whole lot of assumptions. I mean when we walk in and there's two women and we're both Maori. There's a whole lot of assumptions they make and they say they don't make them but, actually they do make them. You know?

So, even then with specialists you've got to be quite up front in terms of getting what you want to know at a level of information you want to know about. I think for ..?.. it's similar too you know, the information they have and how they do things not necessarily how we do things, you know?

I mean I was thinking about you know just now, and I came out in my early twenties, kind of around twenty/twenty-one knowing there was something different for me. But, see even then there was nothing, there was no information, I just knew I wasn't living in the way that I wanted to in that part of my life. And, really had to kind of move away from the life that I knew at that point and come to Auckland for something quite different. And even then it was really just around meeting people. It was around meeting certain people that that changed for me, and growing confident in that. But, there's nothing that is really public around how to be a lesbian let alone a Maori lesbian, you know?

Definitely you know probably in my mid to late twenties I did a lot of reading but, that was also about shared experiences. That was generally kind of narrative stuff, people talking about how they were and how their lives have been.
Yeah, when I think about it we're actually really devoid of stuff out there in your face in terms of public knowledge so, why do they expect people to have an understanding? Actually, when it's not really out there. And, then if you are.., if you're young or if you're lesbian or gay then it's definitely not out there. What you see is what you get modelled on television, you know certain kinds of heterosexual relationships. They're very nuclear and they're very white, and even when they're black people they're still white in their relationship ways of being. So, we don't actually get any modelling really in any major way. It's major aye really, when you think about it.

Whanau

Maori sexual and reproductive health needs to be talked about differently.
And, then more recently I think just in terms of the work we do and being more around Maori settings and, you know, whanau things.., thinking about whanau things in a different way and more.., I'm thinking about marae and how things happen on the marae and the different ways.., you see, I see lots of different ways of being now. The ways in which we talk about sexuality and sexual and reproductive health, I mean, you know, you can have people stand up on marae now and talk about you know male.., what is it? The male cancer.., you know, I heard someone talking one time about the ah.., what's that cancer that men get?
Prostate cancer, you know but in a real Maori way. And, whereas that sometimes it seems flippant and thing but it's just very humorous but, that actually is the way you get it into our people, understanding that stuff. So, I'm more conscious now around that type of learning than what I would have been even ten years ago probably. So, I think that in those contexts it is often there but, we just don't see it for what it is in terms of understanding the deeper parts of what people are talking about. But, then our colonisation is such that that communication has been stopped in many contexts, and definitely minimised.., generally. I don't think the majority of our people have access to that kind of communication. It definitely isn't a conscious programme of it you know, of how you come to know about sexual and reproductive health issues. Not in my mind. But, we get all the crap that's associated with it, you know? And, I mean it's like what you were saying before that the focus is on young people, on Rangatahi as an issue. I think we need to reframe it you know?

The information is not available and, especially if you don't the resources to go out looking for it. I mean it's quite and indictment really given that sexual and reproductive health is you know, it's fundamental to a society you know?

Teen Pregnancies

Public health messages that can be damaging and are really about social control.
There's a lot of that pregnancy help stuff out at the moment. And, I mean you even hear them on Iwi radio and stuff, and if kids, you know young people in particular because that's often the focus on young people having babies too young or whatever. You know, if they don't actually have other support systems they get really caught up in that and that's really fundamentalist that stuff really. That's quite (SPUC) and fundamentalist church run stuff.

There is a difference between how Maori and Pakeha are responding to fertility cycles, when they have babies and also the usage of fertility clinics for having later babies.
One of the things was that whole thinking around youth pregnancies, it's like what you were saying in there, people want, people assume it's only young people who don't have the information which, we know from our own mates is not necessarily the case. But, too.., and I know that a lot of the Maori providers in terms of the.., oh, some Maori providers in terms of sexual and reproductive health provision and youth provision you know, still buy into that thing of if you're young and you have a baby there's something wrong with you. You know? And, don't like that argument of you know, well look we always had babies young. Because, we died young, comparatively to now. I mean rangatahi as it is now are in whatever age group, which seems to be extending..,
Oh, that thing of.., because I've heard people debating.., because we've always been young having babies. You know? Now, who was saying the other day..? I thought you were saying the other day or, someone was saying that whole thing about you know the assumption that because pakeha(s) are having babies late that we have to have babies late. That middle class white New Zealand are having careers and travelling and then having babies so, babies are being born later, you know. Twenty-eight, twenty-nine used to be old to have a baby, and now it's actually the norm for having your first baby. Having babies into your forties used to be relatively unusual except for big families. I mean, my mother had babies into her early forties but, she started in her early twenties and had ten of them. So, they just kept popping out you know?

So, there's a whole shift in when you have children, determined by a whole career.., you know, which our people are not.., don't have access to anyway in the same way. We don't have access to the overseas travel, we don't have access to the educational opportunities and the career opportunities that middle class New Zealand does. You know, but actually the way we have babies is meant to be determined by that as well. So, we're meant to be having babies in our late twenties anyway but, actually we're still having babies in our 15's and 16's, 17, 18, 19 year olds. And, for some reason there's something wrong with us now, you know there's actually something wrong with us because, we're having babies in our teens and early twenties and that's considered young.

More critique of the teen pregnancies discourses.
Yeah so, the whole thing around there's something wrong with having a child at fifteen or sixteen, I just don't believe that. I don't believe that there's something wrong with that. If you have the right support systems and.., well particularly whanau aye? It is about having whanau around you. Whether that be your birth whanau or whether that be your friends or whatever but, there is a whanau context around you to have those children. I've heard people say you can't use that argument that we've always had kids young, well actually, it is an argument and it's a valid argument. And so, how are we.., how does society construct when it's child bearing time? Because child bearing time used to be early twenties you know? It's now late twenties and I just.., and in fact I think that whole movement has had a huge impact on how we see young people having children.

It's like.., see, I don't know whether you're talking to young women who have had babies but, M's niece, and she'll probably talk about her anyway but, she's fifteen and she's got this beautiful little boy and she was determined she was going to keep him. Now, she's got M, and her mum, and her whanau and her nan and all them around her all the time, constantly with her. But, she made a conscious choice to keep that child herself and to raise it herself with their help, you know? And, she's gone back to one of those schools for young mothers and doing her NCEA and doing all that stuff, and of course it's hard but she's made that choice so, you know she's an intelligent young Maori woman, and you know? She's made a clear choice and she's sticking by it. There's nothing wrong with her but, everything out there is saying there's something wrong with her, you know? I think it's just in the way our people have constructed it, particularly, our young people are being constructed as being naïve or, uninformed or, just stupid or whatever, if they get pregnant before they're twenty. And yet, they used to be or, that would have

been the norm in terms of.., you know, if we go back to our early history because we didn't live to eighty, ninety, a hundred. So, I think the whole way in which we construct age is really important too.

Fertility

A lot of the fertility stuff is aimed at the forty plus age group. They try to extend the fertility cycle.
Yeah, and leaving.., leaving your opportunity for having your first child to later in life makes it more difficult to conceive, and more difficult to hold a child and brings all the other possibilities in terms of defects. I don't like that term but, so.., I mean there's a huge amount of money going into that area which, is a lot to do with women waiting to later in life to have children. And, actually it's not about the fact that they couldn't have them in fact, they're probably extremely fertile in their teens and early twenties but, as they've left it that's decreased yeah, that possibility for them.

Rangatahi

What is Rangatahi?
Hui Tuakana they call it. Kaapua fit's right smack in that and she's great for that but, there are people in there who are heading forty you know? Mid thirties heading forty or, even over thirty and they're in the Hui Tuakana and they're Rangatahi. And, I'm just sitting there thinking when did that become Rangatahi? Because, actually, they would have been kuia, koroua 150 years ago.. When we worked at P, Rangatahi was basically up to eighteen. It was that fourteen to eighteen age group was Rangatahi. And, within that age group all of these things happened to those young people that we worked with. But, by the time they hit eighteen they were on their way. They'd made decisions, whether they were good or bad decisions so, they'd made them, they were living them, they were independent, they were out there doing things. And, they're still young people but, they weren't Rangatahi in the sense of that fourteen to eighteen year age group.

And, then Rangatahi became kind of fourteen, I remember a shift from fourteen to kind of twenty-one, and then when you're twenty-one, and that's a real pakeha land mark but, you know age mark. And, then it kind of became.., I remember talking to M and it's like you know, fourteen to twenty-five, you know? Because she was twenty-five so she was Rangatahi, and then you know what I mean? And, then more recently the kind of fourteen, fifteen to thirty something.

And so.., but, at what point actually do you actually have to say no actually that's not.., that's not where Rangatahi fit. It might be in your mind set. You may be young in your mind but, actually in terms of life consequences, experiences, obligations you know, at some point before thirty you know, you've got to kick it. You've got to get away from that thing of trying to hold onto some sense of being a Rangatahi. And, I think people argue that they are Rangatahi, and I just think they actually just need to do their obligations. Which are actually adult obligations. You know?

And it's different, you put a fourteen and a fifteen year old, and an eighteen year old, and a twenty-five year old, and a thirty year old in the same room and they're different. Aye? In the way that they experience the world, they are not the same. So, you can't put someone like S (he's 40) next to even someone like T (he's 22), you know? Totally different. Yet, both could be said to be Rangatahi under this new definition of young people.

Kaupapa Maori Framework

I mean it's like Kaupapa Maori, it's the same thing. I think you've kind of got to lean to your Kaupapa Maori provider question. Anything that we want to reconstruct in this context, re Kaupapa Maori, we have to start from the Kaupapa Maori place. I think that's really where we get a whole lot of confusion and the manipulation of things Maori too. It's like people are still sitting in the western framework and taking the bits of Maori stuff that fits. Which is a very Taha Maori approach you know, which is what that's is about so..,

If we want to be a kaupapa Maori provider or, have a kaupapa Maori analysis we actually have to.., and it's not easy to do and we muck up every.., I mean I don't know people who don't muck it up in some.., you know at different times. Because, many of us are relearning it. But, if you don't start form the fundamental point that tikanga, kaupapa Maori Matauranga Maori all those things of where we're going to base our understanding then everything you do is still framed in a western frame work. So, that's the beginning point is actually starting there and then going out and looking.

So, in that sense everything that is western actually requires an analysis because sits outside of a kaupapa Maori framework, and the same with providers for me. If providers are not beginning on a fundamental kaupapa that is Maori whatever that might be in their context, in their hapu.., I'm talking whanau, hapu, iwi context or urban context, how they construct that themselves or, how their people construct it.., see because I'm still kind of in this place at the moment where I'm really questioning who gets to say if you're kaupapa Maori or not kaupapa Maori.

Some people say you are because you are, and that's fine but, we're in an environment where kaupapa Maori has been coopted and manipulated and exploited. And, at some point I think that we do need to be able to say, 'Actually what you're saying is not kaupapa Maori.' That that is not actually fitting in this context, and for some people that is about being judgemental or whatever. But, I just think you know, we have to at some point, we have to make some stands around what that is for ourselves.

Yeah, so I think that in terms of that question around the western construct stuff it's all up, I think, and it's all flawed. Because, the western constructs of sexual and reproductive health is based in a western notion of the individual and the western notion of the nuclear family, and western notions of relationships and how they should be prioritised and normalised, and constructed. Now, all of those are basically.., they're.., in conflict with a Maori construct of the individual which, we do have one, we have a Maori construct of the individual which is not the same as the western construct of the individual.

It is an individual within a collectiveness, within a whanau, within a whakapapa, within.., it is a being who may stand as an individual but, we're not alone you know? It's hard to.., because western theory is so much about.., talking about an individual soul, and individual personality da, ra, da, ra, da, and all that stuff.

I think Rose Pere is really good at that individual collective relationship thing where, she's always saying, 'I am a person but, I'm a person in this context.' It's like her perfection stuff which people think are wiffley waffley but, I think it is right. You are perfect in yourself until you become compared. You know?

And, some will say this happened and that happened, well you know it is actually about your own inherent being, and if you take that then we all have a perfection and it's really hard to demean people who you believe to be perfect in there own.., you know. Unless you are comparing them to another notion of perfection. And, I think there is something in that. In English it's not the same. It's when she speaks it in Maori but, the essence of it is still.., like we are the embodiment of our tupuna and I guess when you go in to look at things she talks about in terms of the kupu; mokopuna, tamariki, he ariki nga tama, and he aha te tama e te tane, you know? Tama is child not boy, not girl, it's child. So, it's not only that these are little people in terms of 'riki' but, that there is an 'ariki' essence in every child. You know, if you treat that child like that.., Then, the way we see sexual and reproductive health is really different to how we are given it.

Sexual and reproductive health should always begin with te tapu, te mana, te mauri o te tangata.
So, I just think there's lots and lots and lots of stuff in there. The colonisation stuff we can pull apart and we do pull apart. But the nuclear family stuff, all of that it's the whole biblical thing of the child being born to two you know, biological parents in the sanctity of a Christian marriage and there's within that marriage the woman are the possession and the chattel of.., you know all that stuff which goes back to that very early colonising context. Now see, all of that still exists and I think that probably some of our providers still in a very.., even probably not even conscious way, continue to maintain that because they don't question that, you know?
Single parents, the response to single parenting, you know all that stuff. That's a response that's actually based in a nuclear family model. A western nuclear family model or, we wouldn't have that kind of response. We wouldn't have it but, we do. It's a whole lot of assumptions.

Sexually Transmitted Infections

Yeah, like the infertility rates are going up through the roof because of chlamydia, and because of environmental toxins. Interestingly too, from what I can see of the STI stuff they're focussing on the male ones not on the female and it's chlamydia that's through the roof. It's women's fertility that's really at risk. But, it seems to be from what I can see of the funding approach, the whole area of their focus is on the male..

Western Notions Of Sexual And Reproductive Health

Western notions of sexuality are primarily located within the idea of the separate, independent and often fragmented self. there is a colonial fixation with individual expression that ignores or denies collective responsibilities and relationships and as such we see a whole range of unhealthy ways of being. the fundamental definitions of where we fit in the world and in relationship to each other are developed from that way of being and create and affirm an approach that is about individuals and the nuclear family.so things that spring out of that are problematic for cultures that work in relationship with each other or affirm collectivity as a fundamental base.

Has our tikanga been influenced by western notions sexual and reproductive health? If so how?
Our experience and practice of tikanga is severely interrupted by western notions. Ani Mikaere's thesis is one of the most clear expressions of the multiple ways in which this has happened. the colonisation of our beings is multiple. it has reached into every sphere of our lives to the extent that at times we seem to believe that things that were imported by our colonisers are tikanga. that is a huge issue and until we are willing to reflect critically on our own actions, values and beliefs this will continue to be an issue.

Did we talk sexual and reproductive health in the old days?
What are our ways of talking about sexuality?
What are our ways of talking about reproductive health?
Yes we did. We talked in many differing ways. Through korero. Through waiata. Through haka. Through whakatauki. Through purakau. Through whakaairo. Because sexual and reproductive health is about who we are, how we survive, how we live, how we relate. Its about our tupuna, its about us, its about our tamariki, mokopuna and the generations to come. I could not image why we would not talk about it. Not talking about ourselves - that seem ludicrous to me.

Kaupapa Maori And Kaupapa Maori Service

If you think about things in terms of kaupapa Maori, you know community and whanau wellbeing, we need to be trying to build ways in which we can make decisions as families, and as communities and as hapu and iwi. I think that after 150 years of colonisation it's really hard sometimes to make decisions and to think of things in an inclusive way. I think about my own family and things that have happened with my children, and how sexual and reproductive health is packaged in Western society…sometimes they've often found it hard to say things to me like 'I really need some help' because society says that those are private issues and they don't get discussed publicly and they're individualised. But you know, because of the strength of my relationship with my kids, they've got over that and we've been able to talk and make some good whanau-based decisions. But it hasn't been easy for any of us. We've had to learn new ways, ways that run counter to how Western society wants us to function. We've found ways of continuing our values of whanaungatanga and manaakitanga and tiakitanga. We didn't fit with the service providers. I can think about a couple of occasions where I needed to push the service provider really hard and reassure them that my daughter or my son was happy for the service provider to talk to the whole family about an issue. The service provider thought that I was asking them to break some sort of professional code of ethic…

What does a kaupapa Maori service look like?
I think a kaupapa Maori sexual and reproductive health service is a liberatory service. I think the service provider needs to be able to go beyond what has been defined by contracts and by Pakeha worldviews about what sexual and reproductive health is. The most unhealthy aspect about sexual and reproductive health is the extent to which it is over laden with Western values of individuality, secrecy, morality, discrimination, homophobia; and in these ways it is hugely skewed against what kaupapa Maori is.

A kaupapa Maori service should be staffed by all Maori staff, and governed by Maori, and it should be very strongly linked to iwi or linked to the manawhenua of that area, so even in the city it would need in some way to be linked to manawhenua. And it must be about self-determination, so whatever happened in the services, those services need to contribute in a real way to our self-determination, otherwise if it doesn't, if all it does is maintain the status quo, if it never challenges or highlights the power structures and the inequities that keep us oppressed and marginalised in our own country, then it works against us.
This is set up as a kaupapa Maori organisation, Te Puawai Tapu. It's set up in a certain way. But, there was problems how internally and externally kaupapa Maori is defined. It is an interesting one. It's a little bit like that tikanga Maori.., when someone says, 'Oh. But, that's not how we do it,' or, 'that's not right.' There's always this dicey thing of.., we were kaupapa Maori but, maybe we were just taking on say values from.., focus because we're Maori and that makes us kaupapa Maori.

I've heard various things. Because we're Maori then it's kaupapa Maori. Because we're by Maori for Maori then we're kaupapa Maori. But, then I've heard well, we don't incorporate tikanga into our programme so, we're not kaupapa Maori. We.., we've done a couple of te reo programmes but, they've really been translations of our existing programme so, it's not really kaupapa Maori. We don't talk about.., like Te Wharetangata and.., and other things like that so, we're not really kaupapa Maori.

I think it was seen as being something always in development, always evolving to what felt like a kaupapa Maori organisation. I think because.., we didn't feel.., or, the organisation didn't feel that places like Family Planning were doing the best for Maori.., and we thought we could probably do it better. I don't know because, we haven't had the evaluation to really confirm that but, I think the feeling is that we.., we would be more effective than non-Maori organisations.
And, I think for a long.., anecdotally, there was always that feeling that.., feeling born out by educators giving feedback that, the Maori students really related to having Maori educators. And, therefore they were responding better to our programme than if say.., if a Pakeha organisation had been delivering it.
How else to put that it has become a kaupapa Maori organisation? I don't know. We've had Kaumatua in here and we've had people you know, experts in sexual and reproductive health and they haven't been able to really guide us. And, I think it is.., part of it is around ensuring that.., what is it? That the.., traditional but perhaps romantic view doesn't.., or, is still applicable for the groups of Maori that we work with. Yeah.

It kind of goes into well, what's a Maori? You know, what is Maori? What is being Maori? And, how much Maori things do you have to be doing before you can be called Maori? It's the same with.., it's kind of like, degrees of kaupapa Maori. We can say.., well, the organisation can say, yes it's kaupapa Maori but, to what degree? And, no one's has really defined the degrees or the.., or, the stages where it's considered kaupapa Maori. And, even because our structure is set up in a Pakeha system. It's a trust. It's not an iwi authority, it wasn't set up by iwi. So, does that make us.., non-Maori because.., not kaupapa Maori because of that? Or, are we just a Maori organisation?

I think they would see us as just a.., a.., Maori organisation delivering sexuality education programmes. We don't come in and purport to show them the Maori world view of sexuality, and if we did..? Well, first of all like we'd have to find to what that was ha, ha, ha. And, then how would it apply? You know, because, it.., young Maori and their experience in the world and their experience with Maori world.., it may not gel, anyway.
So, in a way although it would be a wonderful.., kind of exposure it may be just like a re-colonisation without it being a decolonisation. Do you know what I mean? So, it's just.., so it's like just putting something on top without having the whole exposure to what being Maori is.

When asked if their service was kaupapa Maori, there were different responses.
If it's to do with funding and the criteria that that funding runs my service is operated, then I'd say no it's not a kaupapa Maori organisation. But I'd break all the rules. And I'm sad to say I can't work any other way. And it's no set method because everybody that comes through my door is different. They may be Maori but they come with different problems. And a lot of it is, will be experience and one has to admit that a lot of the taonga's, a lot of the tikanga and a lot of the kawa of our people is lost. We can only use what's there, and maybe that's not enough. So I'm very interested in Indigenous as the recollection of tools that we have lost. And some of ours we share to other Indigenous people so that they ignite and rekindle what they've lost because for somehow or whatever, in terms of the world of the Indigenous people, they were all of the world and the elements. So I tend to like certain different practices of other cultures because it feels right to me. And you know, if anything's about manaaki and awhi it feels right for me then. I will use that. But I suppose to kaitiaki that it would come under the heading of Maori. If it's takataapui then that again is different because it brings in double trouble but it's working with the taharua, you know the female and the male in the one, working with the one person. So it's about how you tiaki that persons hinengaro, that persons wairua, that persons tinana. And you have to be very mindful of keeping that person in tact. In some ways it's being, you know, if you use the term tohunga or practitioner in my life experience, that gives me that tool as a practitioner, but for me to say I have my PhD in that, it's my people or my peer group that tautoko me.
I didn't have to go to a university to get that. The support came from my community. And if my community are saying, 'we don't want you,' well then it's time to pack your bags and move. But right now there's been a lot of respect and acceptance of me and what I do. For me they are my judges.

What a kaupapa Maori service looks like:
I think a kaupapa Maori service would be all encompassing of tikanga and culture. I think the best example would be to use Kokiri which, is a group operating in Seatoun in Wellington. Their's is Marae based and so, they have all these services on site. There's a lot of education that goes on there so, they have conference rooms where we go in and do training around HIV

Aids prevention. They often invite social workers from other.., regions around Wellington with which we go and present to in terms of training trainer social workers, and Maori community health workers and things like that.

There is a need for more trained professionals in Maori community health. The iwi health services would agree but often the contracts don't allow for it.
But, I'd also like to see more trained professionals. Trained Maori professionals in the kaupapa Maori service. Because, too often our kaupapa Maori health organisations or, hau ora a lot of Maori community health workers that aren't specifically trained. They're just like people who have had a bit of experience and then get thrown into the deep end. Which is a dangerous thing because, Maori community health workers have you no real safety in terms of like.., say the Nursing Council, they do not get covered under that, at present.

If professionally trained, a better service can be offered.
I guess.., well, it depends on what area that they go into. If it's stuff like.., well, we'll just use nursing because it's pretty important. If you go around and start to check some diabetes, and there's.., cholesterol levels, blood pressure, maybe the odd injection every now and then.., if they get trained for.., an Iwi Nurse.., so all of the kinds of safety precautions in terms of domestic injuries. What is a normal diabetic range, and kind of.., tailored to a Maori perspective or, what a normal diabetic range is for Maori. Because, too many of the models are based on western views and quite often we don't fit into those little square boxes. So, it maybe normal for Pakeha but, it's not for Maori. Not saying that you know, people living with a diabetic level of 56 is normal.
And, there should be some research and they should be trained about diabetic range. And, knowing the rationale behind the levels, knowing the reasons why you're taking things. Because a lot of people don't know, and they kind of make it up on the spot. Ha, ha, ha. And, why are people monitoring blood pressures or, heart rates? It's because you know, it's in relation to the medication that's being taken. These are the ..?.. for instance, for heart medication. Can't be given if the heart rate's under 50, things like that. So, people need to know the kind of.., the fundamentals of what they're doing. Yeah. And, that's with just one kind of example. That's just confined to medicine, and then you have all the kind of other social services that are included like counselling, support services, yeah.

Also I think, that if there is to be a kaupapa Maori service it should always have a Kaunihera Maori as well. Like with a trust board, that they're made up of representatives of the community, and it's where kaumatua and kuia have valued input into the running of the service. And, that it maintains the tuakana, teina kind of relationship but, also ensures that tikanga is always a part of everybody's every day life, in terms of providing.., And, cultural safety those types of things.
Because.., you will.., kaupapa Maori will encourage.., non-Maori to join because that's always going to happen. What it does is it creates a precedence of safety for non-Maori to come into a service and work along side Maori, best practices and it values that person. That non-Maori individual, it values them.

And, I think that.., to have a kaunihera you have to have people with skills, and you have to have people who are realistic too. So, you can have all the tikanga in the world but, you also need people that I suppose, know what the every day lives is that a lot of Maori people lead, you know? So they need to be able to relate to the majority of our people. You have to ..?.. because sometimes there is a bit snobbery amongst Maori so.., You don't have it as much as Pakeha people but, sometimes it comes through. So I think practical solutions. If they come up with practical solutions and practical strategies for our people I think that can work.

This Interview Gives An Example Of How Educators Are Trying To Indigenise Their Teaching:

I'm the Sexual Health/Mental Health Promoter for Public Health. Yeah, I came from an iwi environment before I started working for Public Health nineteen months ago. And, I actually fell into the role of sexual health. My passion is mental health but sexual health was part of the role that I took on, and I actually found I really enjoyed doing that component of my work. And, it seems to take up a bit more than it should. Working with rangatahi too, they're awesome, they're awesome to work with, yeah. So, yeah that's basically me in a nutshell.

The only Maori Sexual Health Promoter within the region was taught by one of the health workers about the whanau concept. You know, about whanau, hapu and iwi, and the importance of whakapapa, the importance of Ko Wai Au - starting with yourself. And, so she actually taught me that concept. When I go into the schools to talk to rangatahi it's about, you know, their own personal stuff around the Ko Wai Au. And, then the whanau, then the hapu and the iwi.

KEY FINDINGS

PART FIVE

Key Findings

This section brings together the key findings from throughout the report. The interviews contained a wealth of information which has been condensed in this section into short statements. The findings from the literature surveys have also been condensed and itemised here. The wealth of information gathered in this report shows the complexity of the sexual and reproductive health area, especially for providers who are having to try to intervene in Maori sexual and reproductive health statistics.

Matauranga Maori

Sexual and reproductive health for Maori builds on ideas of tapu, mana, wairua, te ira tangata, te ira atua, ihi, wehi and a multitude of understandings about our relationships to the past, to the environment and to other humans.
There is a rich body of knowledge that exists about Maori ways of thinking and conceptualising sexual and reproductive health and well-being.
Those who retain and analyse these bodies of knowledge, consider that there is a great deal of work to be done to inform Maori health providers about that knowledge base.
Critical discussion needs to continue within Maori communities to understand the influence of christianity and other external influences on matauranga Maori, particularly in the area of sexual and reproductive health.
Providers indicated that they want to learn more about matauranga Maori in the sexual and reproductive health area but it is considered by some to be incidental in developing interventions in disease.

General

Maori think about sexual and reproductive health much more widely than just in terms of individual health. Sexual and reproductive health is wider and more encompassing than just body parts and diseases. The context includes whanau well-being, hapu and tribal wellbeing, and whakapapa. It is also about relationships and is reliant on mental, spiritual and physical wellbeing. Wairua is also important, as is self-esteem, and confidence. Ultimately, increasing the Maori population is also important.
Stereotyping of Maori is a continual problem. Deficit views of Maori are that they breed like rabbits, that they are overfertile, that teenage pregnancy is a big crisis, and so on. But there is actually an infertility crisis which is not being looked at, especially with the high incidence of chlamydia among rangatahi.
Sexual and reproductive health is not just about rangatahi, sexual health is lifelong e.g the 40-60 year old Maori male group who are likely after marriage break ups to engage in unsafe sex. Most of the Sexual and Reproductive health focus is towards rangatahi.
Sexual and Reproductive health is tied into social control and population control.
There are a range of Maori views about what sexual and reproductive health is: 'traditional', fundamentalist Christian, romantic traditional, liberal.
There are some fundamental differences in the way that Maori think and respond to sexual and reproductive health, e.g children were not seen as personal property but as a shared responsibility.
Our interviews showed that it was very rare for Maori to learn about sexuality within the whanau. There is much work to be done with whanau. It's been left up to mainly schools and peer groups to inform tamariki and rangatahi.
The area of sexual and reproductive health emerges historically from one of fertility control. There needs to be a complete revisioning of the area.
Racism within health provision is still prevalent. Historically Maori were targetted for population control because they had big families.
There are connections between sexual and reproductive health and rongoa, whakairo and ta moko, etc.

STIs

Clinics are dealing with STI's, contraception, aborton and pregnancy. The majority of people (approximately 80%) go to a GP rather than a sexual health clinic.
Sexual health clinics are busy on Mondays, after the weekends, when the emergency contraceptive pill is sought.
There was concern expressed at the lack of attendance at follow-up appointments by rangatahi once treatment has occurred (so there is little time for education for prevention, and little time for tracking others who may have contracted an infection).

Nurses noted that there is not enough time for education.
There is a high incidence of STI's among Maori rangatahi and growing chlamydia and gonorrehea rates. (Consequences can be sterility for women and men)
STI infections are more likely to be identified during pregnancy check-ups.
STI's are connected to drugs and alcohol.
Historically – ESR reported cases of gonorrhea and herpes but not chlamydia. Only in the 1990s did they begin to include chlamydia which impacts on women mainly.
Gender differences were noted in the way that rangatahi sought help and medical attention but this needs further research.

Teen Pregnancy

There was a reasonable amount of discussion about teen pregnancy.
Data on teen pregnancies is not well collected e.g Tests in clinics can be negative but still counted and positive tests can result in a termination which can also not be counted.
Many of the Maori interviewees had direct experience of teen pregnancy in their whanau.
Unplanned pregnancies are not necessarily viewed as negative among Maori.
More support in schools was emphasised as a need for teen mothers.
Support groups for teen mothers are important but rural areas may have no such support.
Teen pregnancy is not always indicative of a lack of communication with parents.
A teen pregnancy can help to mature a teenager.
Maori girls can end up in abusive relationships if they dont understand themselves and understand relationships.
There was criticism of the condemnation of teenagers who became pregnant.
If teens fall pregnant, they need good support, whether they decide to keep the baby or not.
Whangai children are usually not stigmatised in the same way as adopted or foster children can be.
Trust has to be built with young mothers.
There are many young mothers who do not have active whanau support.
Teen pregnancy can be just one aspect of multiple factors that are affecting the health and wellbeing of young Maori women e.g they may be being monitored by CYF's, there may be lack of housing, and dealing with WINZ, etc. Without support on these wider issues they can struggle.
Teen pregnancies can be unexpected but they are rarely unwanted.
Education about sexuality needs to continue with teen mothers.
Abortion rates for Maori are relatively high; Asian and Pacific rates are higher. Access to abortion services can be difficult especially for rural women.
The rate of babies being adopted out is dropping. (Adoption = formal legal adoption as distinct from whangai)

Indicators Of Wellbeing

Maori workers discussed what they considered were indicators of wellbeing:
Whanau communication is important - providers working with whanau.
Socioeconomic stability.
Tino rangatiratanga – the right of whanau to stand and make their own decisions.
Information sharing within whanau that does not marginalise individuals.

Providers

Maori providers are few and far between.
Maori providers deliver services to all ethnicities.
All Maori providers offer a range of health services (except Te Puawai Tapu which specialises in Maori sexual health education).
One rangatahi Maori and Pacific provider covers the whole of the greater Auckland region.
There is only one kaupapa Maori provider in the whole country that deals with whakawahine and sex workers.
Maori providers actively work across sectors such as alcohol and drug abuse, and mental health.
There are differences between Maori and Pakeha provision and training methods.

Providers said that they wanted to extend beyond just youth services but the funding is not available.
A number of providers saw the need for networking as the area has developed in such an ad hoc way that it needs to be consolidated and the sharing of information and resources would be invaluable especially considering the lack of training.
Some work needs to be done by providers to increase their networking and working with mana whenua.
Providers are involved in lobbying for policy changes by attending DHB and Ministry hui.
Sometimes there are tensions between the health educators and clinicians when it comes to sexual and reproductive health.
There is a lack of research on Maori sexual and reproductive health to provide a body of knowledge that informs Maori providers.

Nurses

Maori Sexual and reproductive health workers generally are found in a number of areas e.g iwi health, public health, DHB, PHO's, Maori health providers (in both mainstream and outside mainstream)
The numbers of Maori nurses working in sexual health is very small and they are required to cover huge areas as Maori client preference means that their workloads and regions are large.
Adolescent health nurses can only deal with ages 14 to 24 which can be a limitation.
Access to sexual health clinics by rangatahi, especially rural rangatahi, is a huge problem. Times of clinics, transportation, and confidentiality issues can be barriers for rural rangatahi to access service.
There are only two nurses that we found actually attached to a Maori provider that provided specialist sexual services. These two had to be able to work more widely than just sexual health.
General nurses attached to Maori providers are unlikely to have the training required to deal with sexual health and are so busy on general health that they are unlikely to have time to do additional tasks.
Two views emerged about which nurses were better – one view that you needed younger nurses who relate to rangatahi and the other view that you needed older nurses with life experience.
Criticism arose about younger nurses not having adequate cultural safety training to be able to appropriately deal with elderly, with ethnicity etc.
Adolescent nurses are required to follow up on sexual contacts if an STI has been identified but drugs and alcohol can mean that the person may not remember who they slept with.
WHO assessment methods are utilised to determine contraceptive prescription.

Schools

Establishing and maintaining good working relationships with schools is time consuming and ongoing for providers. It's a big part of their work.
Sexual and reproductive health is usually not taken that seriously by schools.
There are huge differences between schools.
Schools vary on their emphasis on health generally and also on sexual and reproductive health. Some see health holistically and some don't. Schools vary on what they teach according to how they interpret the curriculum e.g sexual health teaching can focus on morality and sin.
There is a view out there that sexuality education is about sex but the bigger component is teaching about relationships and life/skills.
Schools determine how much or how little time is spent on the subject. So time spent on the topic is varied.
In some cases schools are quite prescriptive about what they want taught so educators have to have flexible programmes and modify accordingly.
Teaching in the sexual and reproductive health area is specialised.
Those teachers that were interested in providing programmes in their classrooms were sometimes not supported by the school. Other teachers either were too busy on other things or were not interested. Teachers need training to teach in the area if they choose to teach. Working in schools requires creative thinking to assist teachers who already have heavy workloads.
There appears to be high mobility among teachers and so there is not necessarily continuity in schools with a trained teacher in the sexual health area.
Most of the providers we spoke to work not just with pupils in schools but also make their programmes available to parents, teachers and other organisations.
Quite a bit of work still needs to be done with schools giving emphasis to the importance of sexual and reproductive health.

There is a legal requirement that before a sexual and reproductive health programme can be implemented, it must get school Board and school community approval.
Adolescent nurses are no longer allowed to teach in schools; it is teachers or contracted educators. However, they can support staff and students. Adolescent nurses can cover large regions which means they can be very stretched to cover schools in their regions.
Schools vary on how they see Treaty rights and how they support Maori students.
It was suggested that iwi providers be more active about working with schools.
Creative ways are needed to include whanau.
There was concern expressed over new immigrant teachers who don't have Treaty awareness or Maori awareness.
More research needs to be done on the long-term effectiveness of existing programmes in order to inform providers on the success or not of their programmes.

Rangatahi Education

There are contradictory opinions about what rangatahi know about sexual and reproductive health. Some interviewees said rangatahi knew a lot and others said they knew very little. There are urban/rural differences, there are differences in access to sexuality education, there are differences in whanau education, there are differences in literacy levels (reading, IT etc) and the knowledge base appears to be quite uneven across rangatahi.
Whanau, hapu and iwi in general are not doing sexuality education with their own tamariki.
Peer sexuality is emphasised as an education method.
Youth resources exist, such as the PHAT pack.
Some educators say that there is important basic information that 14 and 15 year olds don't have, even though they can become parents during that time.
Comment was made that there is a 'new generation' of hurting young mums and a 'lost generation' of rangatahi trying to find themselves. Teen mothers were talked about in this way: girls who were looking for love, 'Lost generation'. Teen mothers need support, especially from the extended whanau. Teen mothers have little support available if their whanau is not supportive.
Self respect is a key point to learn.
It is important to go to places where rangatahi meet e.g kapa haka, sports venues, festivals, manu korero etc
Some educators are using the HEADSS assessment tool for assessing sexual health needs.
Trust and privacy is critical for rangatahi. Difficulties can arise such as the only GP in small areas is the whanau GP. Without trust they are unlikely to seek help until late.
One strategy for ensuring privacy for rangatahi is to run general adolescent health clinics rather than sexual health clinics.
Several people commented that it is common for 13-17 year old Maori to have multiple partners.
It is important for rangatahi to have knowledge of whakapapa.
It is seen as important to understand when a person is being manipulated or bullied into having sex.

Communication With Rangatahi

Good skills are required to communicate with rangatahi and to be able to do so from a Kaupapa Maori base. E.g being able to be up-front, being able to make students feel safe, presenting information in a variety of ways such as kapa haka, drama, knowledge of pukorero.
Language used is important – terms need to be simplified and common terms should be used.
The importance of providing information of relevance to contemporary rangatahi was mentioned.
Communication skills are important for developing healthy sexual relationships. This usually needs to be taught.

Provider Training

Training is provided by Family Planning and independent practitioner associations. There is little or nothing that is Maori.
There are some resources available but little to nothing that is Maori.
Some providers organise their own training.
Kaupapa Maori provider training is urgently required.

Takataapui

There is a wide range of whanau responses to takataapui; some are supportive, some are indifferent, some reject the person.
There is still a long way to go for takataapui youth to feel safe, accepted and comfortable in a range of environments e.g school and home. There is a queer youth programme in a few schools, but Maori queer youth are hardly recognised as having their own identity. There are a lack of resources for queer youth. The Ministry of Health released a queer youth resource but it was controversial in many conservative schools.
Pressure on takataapui youth is one of many contributing factors to suicide. Teachers themselves also feel unsafe in schools to be out.
There is a belief that because teens are in developmental stages of life and sexuality, and that they are experimenting with sexuality in their teen years, that heterosexuality will win eventually if you just dont talk about takataapui identity.
Homophobia is a christianised influence on whanau. Work needs to be done to restore the wider and inclusive meaning of whanau.
Whanau want whanau-focused information, not individual counselling that supports takataapui members of whanau and each other in the coming out process. The only whanau education done is by the AIDs Foundation Maori educators.
Takataapui are working in a wide range of places and jobs and visibility is growing slowly.
Sexual health messages are mainly targeting all youth but to be more effective they need to be culture specific, factual and developed as a multigenerational strategy i.e not just focused on rangatahi.
The Gay community lobbied and won service provision for HIV.
Promotional messages need to be intergenerational and a complete campaign from tamariki nohinohi to kaumatua.
There are varying views and acceptance of the term takataapui.
Takataapui in rural areas can lack support from whanau and from others.
The Homosexual Law Reform in the 1980s created a stronger political stance by Maori and Pakeha, and in the process Maori focused on Maori sexual identity and created the term takataapui. Takataapui writing has emerged more strongly in the last 10 years.
HIV/AIDs workers are developing new education strategies by going beyond the gay male community and their meeting places.
Controversy has emerged about the place of tikanga when representing sexual identity e.g the Warriors for Safe Sex poster, the wearing of moko kauae by men in another poster, etc.
Comment was made that it is harder to come out as a gay Maori male because there is a perceived higher physical risk than being lesbian. Wahine takataapui visibility can be overshadowed by the heterosexual community and gay male community.
Role models and tuakana roles were identified as important for takataapui.
Safe places have to be developed to provide support and guidance for rangatahi who are questioning their sexual identity.
The Whakawahine community is barely recognised even within the takataapui community generally.
There is a need for recognition of intersexual identity.
There is a lack of gender construction of identity and deconstruction.

Whanau

Importance was placed on whanau as additional educators, but they clearly need discussion and support.
Who has the ultimate say – whanau rights or individual rights? Interviewees differed in their opinions. Some said the individual if the whanau were overriding sexual identity. Others said whanau on most matters.
Whanau education is more than the parents or care-givers. Education can come from a wide range of caregivers and generations.
It was argued that educating Maori women was a priority as they are directly responsible for the next generation.

Funding And Contracts

Providers say funding for sexual and reproductive health education is limited, patchy and insecure.
The funding is not always responsive to providers changing needs e.g. providers are often underfunded when trying to build capacity and client base.
In order to justify funding you have to say in what ways you are different from other Maori providers.
The state of working relationships between providers and funders can be antagonistic because of the changing rules and uncertainty.

Contracts can be competitive and also prescriptive.
Many of the providers work beyond the limits of the contract e.g they work with whanau when requested.
A good relationship with the Ministry of Health is seen as critical for accessing Public Health funding.
High turnover of workers in the Ministry causes problems for providers.

Policy

New Zealand policy is shaped by overseas policy.
The way the Ministry defines sexual and reproductive health is different from the way Maori define it.
Ministry priorities are largely determined by the statistics and crisis areas. Sexual and reproductive health is considered to be about managing risk.
There is some way to go to persuade politicians and policy advisors of the importance of kaupapa Maori sexuality education (Adding a few Maori words does not make a programme Maori). There is still the view that one size fits all in sexual and reproductive health.
There is no sexual and reproductive health legislation on the books, the closest was Sue Bradfords – mothers in prison with babies Bill.
When there is legislation proposed such as the Civil Union, Prostitution Bill etc, these are all conscience votes and parties therefore do not have to have any policy on the subject and therefore agencies don't have to do any policy work on it.
Sexual and reproductive health is fragmented and policy is about managing risks.
Ministries want the Maori perspective but are reluctant to centralise Maori.
Ministry of Health Policy to direct sexual and reproductive health work is sorely missed by providers.
There is a national strategy on paper but regional strategies need to be developed.
DHBs are uneven in their recognition of sexual health needs.
Sexual and reproductive health policy is highly contested by different groups, conservative and liberal.
Maori providers in the sector identify a number of barriers to the implementation of sexual and reproductive health policy and service provision for Maori.
Sexuality as a separate component is not funded by the Ministry; it has to be sexual and reproductive health.
Providers need to be involved with setting priority areas for sexual and reproductive health and contracts.
Contracts also need to be cognisant of whanau, hapu and iwi needs.
Ministries focus on individual rights and do not take account of whanau rights.

WORKING TOWARDS POSITIVE OUTCOMES FOR MAORI

PART SIX

Recommendations for Policy/Government

1. Work With Whanau

There needs to be multiple strategies for Maori. We found that workers tried to work with both individuals and whanau but contracts did not adequately fund working with whanau. Existing whanau workers in Maori communities work across a range of areas. There are lessons to be learnt from not only Maori whanau workers who work with health generally but also those working in particular areas such as alcohol and drugs, suicide, cervical and breast screening, Maori sex workers, etc.
We found that Maori do want cohesive services built on existing whanau services. The preference is to work in one place with multiple service provision. Sexual and reproductive health services and whanau education could be located within existing hauora or rangatahi services depending on what is already in existence. Communities know best what their needs are and where services need to be situated.
In urban centres the Te Puawai Tapu model of a specific service could be developed nationally.
Having emphasised whanau, this should not be at the expense of rangatahi or other groupings, e.g takataapui wahine and takataapui tane, which predominantly work with whanau anyway.

2. Provide An Intersectoral Response

There needs to be a co-ordinated whanau approach to meet the needs for adequate sexual and reproductive health services. Sexual and reproductive health is linked to health and wellbeing generally. Issues of violence, abuse, and high risk taking behaviours can be strongly linked to sexual health. This therefore necessitates the need for an intersectoral response focusing on the sexual and reproductive wellbeing of whanau. This intersectoral response could include the Ministries of Justice, Health, Education, Women's Affairs, Youth Affairs, Social Development, and Te Puni Kokiri.

3. Improve Statistics Gathering

Statistics are needed that are more complete and account for ethnicity.

4. Input Into Sexual And Reproductive Health Strategies

Whanau and Maori Providers need to be given the opportunity to provide input into the National Sexual and Reproductive Health Strategy, setting priority areas, and implementing regional strategies.

5. Increase Funding

Funding needs to be increased for Maori providers to:

- develop kaupapa Maori resources;
- increase workforce capacity;
- enable kaupapa Maori training;
- support the set up of national and regional networks.

6. Policy

A key challenge for policy makers is to have dialogue with Maori communities and workers that is free of preconceived notions of Maori as 'the unfit'. Discussion needs to start from a place that does not presuppose the goals, aims and solutions to sexual and reproductive health, and that assumes there is wisdom within Maori communities to identify problems and to find and develop solutions to those problems. Maori would be deeply concerned as a population to know the high rates of STI's, the high numbers of abortions, would want to know about the lives of their takataapui whanau, and would want to be active participants in interventions that can improve health and wellbeing. But there has been an incredible lack of resources and information provided to Maori communities. The only information there is has been in schools and that has been very sketchy. It is important to begin to involve whanau in the strategies for Maori sexual and reproductive health. STI's dont just affect individuals, they affect ranges of people and if left undetected, they can lead to infertility which is a whanau issue and an intergenerational whakapapa issue.

7. Recommendations Made At The 1st National Maori Sexual And Reproductive Health Conference, November 2004.

A host of recommendations resulted from the conference for the future development of the Maori sexual and reproductive health sector:

Sector Development
Explore options to lodge a claim to Waitangi Tribunal regarding Crown failure to ensure equitable outcomes for Maori in sexual and reproductive health
National Working Group (role is strategic planning, implementation and monitoring of Maori sexual and reproductive health)
Regional Maori sexual and reproductive health networks (linked to National Working Group)
National website
National Maori research and evaluation 'agenda'

Services Development
Maori sexual and reproductive health as one of the ten Maori health priority areas. Priority funding and development for 'by Maori, for Maori' organisations
'Stock take' by volume, type, location of sexual and reproductive health services for Maori (both 'by Maori, for Maori' and general population services)
High-quality, comprehensive national sexual and reproductive health data-set, and data analysis based on disparities
Comprehensive Maori sexual and reproductive health contracts (linking clinical and health promotion contracts in sexual health, and ensuring links to cervical and breastscreening services)
'Long-run' contracts
Contracts that reflect the higher development costs in Maori sexual and reproductive health

Workforce Training and Development
More kaupapa Maori sexual and reproductive health education, promotion and clinic services
Nationally-certified kaupapa Maori sexual and reproductive health training (not FPA New Zealand-type training)
Training for rangatahi educators working with rangatahi (including working in wharekura, using te reo Maori medium)
Training for educators working with parents and whanau.

8. Recommendations Made At The Workforce Development Forum Held In November 2003.

The gaps in the current service delivery, and the skills and workforce required to fill these gaps were discussed at the November 2003 Maori Sexual and Reproductive Health Workforce Development Forum.[204] The main conclusions resulting from this discussion were:

Gap identification
"The Report '*The Workforce Now' – A Sector Profile* illustrates how small the Kaupapa Maori sexual and reproductive health sector is in comparison to the 'mainstream' sector. Most of the Kaupapa Maori organisations with sexual and reproductive health contracts have fewer than 40 hours per week available for sexual and reproductive health service delivery. This means that it is difficult for these organisations to specialise in sexual and reproductive health, and to justify staff training and service development and resource costs;
Current contracting in sexual and reproductive health is disjointed i.e. clinical services are separated from health education and promotion-type services. Kaupapa Maori organisations want an opportunity to provide integrated sexual and reproductive health services, and to make these more whanau-orientated where this is appropriate. The ideal for Maori communities from an 'access' point of view is for these services / contracts to mesh together e.g. well women – cervical screening – breast screening – sexual and reproductive health education programmes – sexual and reproductive health clinical services;
Kaupapa Maori organisations require funder assistance to encourage PHO's, for example, to contract for Kaupapa Maori sexual and reproductive health education and promotion services and clinical services from existing Kaupapa Maori service providers, and to utilise PHO access funding and health promotion funding to enable this to happen;
Clinical contracts are funded based on the number of face-to-face 'one-to-one' visits. There needs to be the scope in contracts to allow for funding to support 'whanau' clinic visits in order to educate and empower whanau i.e. rangatahi and whanau visits to doctor about contraception;

204 Maori Sexual and reproductive health Workforce Development Forum, hosted by the Public Health Directorate of the Ministry of Health, held on 19 November 2003 at the Minstry of Health, Wellington.

Kaupapa Maori organisations need funding and support to develop Kaupapa Maori sexual and reproductive health services, and associated service benchmarks. Kaupapa Maori organisations are left to do this developmental work themselves, without any additional funding, without the benefit of access to research, and without the support of other Maori working in the sector."[205]

The workforce in five years
"Kaupapa Maori organisations should be supported to deliver a greater percentage of the sexual and reproductive health services required by Maori communities (i.e. current disparity of 23 FTE in Kaupapa Maori organisations vs 400+ FTE in non-Maori organisations should be reduced);
Kaupapa Maori organisations should be funded at the same price per FTE as non-Maori organisations (e.g. current disparity of $45K for FTE's in Kaupapa Maori organisations vs $70K for FTE's in non-Maori organisations should be removed);
Evaluate the Kaupapa Maori services (i.e. programmes) currently being provided, and grow those services that are working well for Maori communities;
Based on the fact that many Maori prefer to access health from Maori organisations it follows that Kaupapa Maori organisations providing sexual and health services should be viewed by the funder as having 'preferred provider' status over non-Maori organisations providing sexual and reproductive health;
Maori sexual and reproductive health should be a priority in District Health Board (DHB) plans because Maori sexual and reproductive health is in crisis;
Kaupapa Maori sexual and reproductive health workforce development should be a priority for all health funders (DHB's, MOH and Clinical Training Agency) in order to develop a larger, more skilled Maori health workforce. The lack of a skilled workforce is a key factor limiting the growth of Kaupapa Maori sexual and reproductive health services."[206]

Three priority strategies for building the workforce
"Continuation of Forum: An immediate requirement is for funds to enable this Forum to continue to meet. The Forum provides a starting point for Kaupapa Maori organisations working in sexual and reproductive health to strengthen their networks with each other, share successes, share training, information and resources, and develop and articulate key messages about workforce needs, and solutions, to funders;
Service Funding: An immediate requirement is for funding to support existing Kaupapa Maori workforce development initiatives (i.e. staff training programmes) and Kaupapa Maori sexual and reproductive health services, given the current disparities and need;
Promotion of Kaupapa Maori sexual and reproductive health issues.
The Forum mandates Te Puawai Tapu to articulate key sector issues to funders, to Ministries and similar organisations related to Kaupapa Maori sexual and reproductive health workforce development. Te Puawai Tapu is invited to take up this role as it is the only one of all 14 Kaupapa Maori organisations that has a national policy / advocacy contract and is, therefore, funded to undertake this role."[207]

Recommendations for Whanau Whanui

1.Strengthening Whanau

We found that there is not much discussion within whanau that helps equip individuals to deal with sexual and reproductive health. We need to start understanding why we no longer feel comfortable to talk about bodies and sexuality. Issues such as respecting ones own body, respecting others bodies,understanding what is a healthy sexual relationship, respecting difference of sexuality, and how to protect oneself, partner and whanau from disease, are things that are generally not talked about inside whanau. There are new life-threatening diseases being passed through unsafe sex and in the past we did have the ability and ways of speaking about sexuality that are now missing. The depth of respect for the tinana and relationship to others is deeply present in Maori thinking. Ideally Sexual and reproductive health workers would have the resources to be able to work alongside whanau to equip them with information. At the moment there is an intergenerational breakdown, that needs to be remedied. Sexual and reproductive health is being dealt with very reactively and focused only on rangatahi education. If the

205 Ibid.
206 ibid.
207 ibid.

whanau is not strong and supportive, the traditional safety net is not in place. If whanau is working well, they can provide invaluable support and wellbeing.

2. Strengthen Relationship With Maori Providers

There is a need to increase Maori experts in this field, for educators, for nurses, specialists, health professionals, counsellors, social workers. It is important for relationships to develop between whanau, hapu, iwi and experts in this area. This can be done by including sexual and reproductive health in health planning and recognising it as a health priority. This report points to an infertility crisis among Maori which is why it needs to go on the agenda of all Maori organisations.

3. Takataapui Whanau

Although there are changes in respect and visibility of whanau diversity, work still needs to be done to achieve full acceptance of intersexual, bisexual, transgender, gay, lesbian, transsexual whanau. People are still running away from whanau so they can be who they are. The impacts are huge: mental health suffers, suicide and self-harm can result. Other high risk taking behaviours can result directly from rejection such as alcohol and drug abuse, prostitution, unsafe sex practises.

To conclude this report we would like to quote from one of the interviews that gives an explanation to the creation of the human form and the essence that is gifted from gods:

> *The blood and the spirit came from Io, but through Rehua. Rehua, one of the demi-God's, went and asked Io. Io said, 'here, here's the blood, here's the spirit, here's the life essence,' which is that thing that makes life work, gives life form, 'here it is.' So all of that came from them. Then Tawhirimatea gives the lungs. Ruatepupuke and Whatukura gives thought, intellect, reasoning, imagination. And then the eyes were given by Uru, the eldest child of Rangi and Papa. The ability to see, to visualise, came from the eldest child of Rangi and Papa, Uru. Uru-te-ngangana a Whatu. The whites of the eyes were given by another brother who is the spirit of clouds. So the whites of our eyes then come from, Aowhaturia, comes from Aokapua, another brother. Tupai, a demi-God, gives the bones, the skeletal system. Tu and Akakamatua then gives all of the sinew, the muscles. And the list goes on, of the stomach, the throat, and the arero, the ihu, and the lips. But in essence we are the product of this great innovation, this great research, where everybody contributed. And finally this thing was finished. And so the ira tangata, mortals were created by immortals. And the essence of the mortals were the gifts by the immortals.*

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PART SEVEN

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General bibliography;
Sexual and reproductive health theory and literature;
A history of fertility (Eugenics) bibliography.

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Sir Francis Galton's essays were originally published by the Eugenics Education Society in 1909. Collected here are historically significant essays on the possible improvement of the human breed, eugenics (definition, scope, and aims), restrictions in marriage, studies in national eugenics, eugenics and religion, probability (the foundation of eugenics), and local association for promoting eugenics.

Glannon, Walter. **Genes, Embryos, and Future People.** *Bioethics* 12(3): 187-211, July 1998.
Glannon writes that "the testing and selective termination of genetically defective embryos is the only medically and morally defensible way to prevent the existence of people with severe disability, pain and suffering that make their lives not worth living for them on the whole."

Garver, Kenneth L.; and Garver, Bettylee. **Eugenics, Euthanasia and Genocide.** *Linacre Quarterly* 59 (3): 24-51, August 1992.
The authors review the background of the American and German eugenics movements (including religious views of the time), commenting on present day and future eugenic actions. They urge caution, saying that some current medical practices can be considered negative eugenics which threaten the privacy and rights of individuals, and recommend awareness of the "subtle influences of economic pressures and the increasing reliance on utilitarian cost-effective criteria for making genetic decisions."

Garver, Kenneth L.; and Garver, Bettylee. **The Human Genome Project and Eugenic Concerns.** *American Journal of Human Genetics* 54 (1): 148-58, January 1994.
Saying the Human Genome Project will lead to better screening and diagnosis of genetic diseases, and hopefully to cure for genetic disease, the Garvers point out that in the past, in Germany and the United States, genetic information has been misused.

Genetics, Eugenics and Evolution. *British Journal for the History of Science* 22 (3): 257-375, September 1989.
This special issue contains six articles on eugenics covering British, German, and Scandinavian developments. Contents include: Generation and the Origin of the Species by M.S.J. Hodge; Development and Adaptation in British Morphology by Peter Bowler; Dimensions of Scientific Controversy by Robert Olby; The 'Sonderweg' of German Eugenics by Paul Weindling; Geneticists and the Eugenics Movement in Scandinavia by Nils Roll-Hansen; and Biology of Stupidity by David Barker.

Gray, Paul. Cursed by Eugenics. Time 153(1): 84-85, January 11, 1999. [Special Issue: The Future of Medicine: How Genetic Engineering Will Change Us in the Next Century].
Gray thinks that when "science promises such dazzling advances" it is a good time to look at the rise and fall of eugenics which he describes as a "cautionary tale." Eugenics flaws may seem obvious now, but the errors caused "unintended

consequences for millions of people." He urges the public to think of these scientists the next time one hears of "promoting the scientific improvement of the human race."

Harris, John. **Is Gene Therapy a Form of Eugenics?** *Bioethics* 7 (2/3): 178-87, April 1993.
Harris tackles the question of whether we should use genetic technologies to enhance the human race, or to cure dysfunctions, and whether there is a relevant moral distinction between the two applications of gene therapy.

Holtzman, Neil A., and Rothstein, Mark A. **Eugenics and Genetic Discrimination**. *American Journal of Human Genetics* 50 (3): 457-59, March 1992.
Current incidents in the news indicate concerns that negative eugenics is alive and well in the United States. "The threat of eugenics and genetic discrimination comes not only from meddlesome social commentators and political demagogues but from the increasing economics pressures on our employment system that remains largely responsible for access to private health insurance and health care."

Hunt, John. Perfecting Humankind: A Comparison of Progressive and Nazi Views on Eugenics, Sterilization and Abortion. *Linacre Quarterly* 66(1): 129-141, February 1999.
An overall picture of the international eugenics movement is outlined with emphasis on the roles that the United States and Germany played in fostering eugenic thinking. While eugenics is a "discredited science today," Hunt fears that current abortion and sterilization rates along with managed care economics could be a source of concern for a return of eugenics in America.

Huxley, Julian. **Eugenics in Evolutionary Perspective**. *Perspectives in Biology and Medicine* 6 (2): 155-87, Winter 1963.
Huxley holds that natural selection has brought humankind to its present highly imperfect, unfinished type which has a potential for future development if genetic "deterioration" is checked. "...eugenics must obviously play an important part in enabling man to fulfill that destiny." Huxley advocates what he calls E.I.D.--eugenic insemination by deliberately preferred donors...."

Jones, Owen D. Reproductive Autonomy and Evolutionary Biology: A Regulatory Framework for Trait-Selection Technologies. *American Journal of Law & Medicine* 19(3): 187-231, 1993.
Jones presents a model for government protection to allow parents to select certain traits in their offspring while proposing limits in the event the trait were damaging to the future child. He discusses the "eugenic overtones" that this might entail and says that "evil use does not make eugenics evil in nature."

Kevles, Daniel J. **Eugenics and the Human Genome Project: Is the Past Prologue?** In ***Justice and the Human Genome Project.*** Timothy F. Murphy and Marc A. Lappe, eds. Berkeley: University of California Press, 1994, pp. 14-29.
Kevles opines that the "shadow of eugenics hangs over any discussion of the social implications of human genetics, but particularly over consideration of the potential impact of the human genome project." Noting the possibility for both positive and negative eugenics, he thinks that present day public policy will offset any return to eugenics since "the past has much to teach about how to avoid repeating its mistakes, not to mentions its sins".

Kevles, Daniel J. **Eugenics: Historical Aspects.** In ***Encyclopedia of Bioethics. Revised Edition.*** Warren T. Reich, ed. New York: Simon & Schuster Macmillan, 1995, pp. 765-770.
In this overview, Kevles discusses not only historical background, but current genetic concerns including reproductive selection, the Human Genome Project, opposition in Europe to this project, and how economics may provide incentives to negative eugenics. Cross references to several dozen other encyclopedia entries are included.

Kevles, Daniel J. In the Name of Eugenics: Genetics and the Uses of Human Heredity. New York: Knopf, 1985. 426 p.
Providing an extensive history of the development of eugenic thinking and its application in the United States and Great Britain, Kevles describes legislation, court cases, religious viewpoints, scientific flaws, the rise of genetics in medicine, and human genetic research. He concludes that "How the public or politically powerful coalitions, will respond to the steady pressure of problems raised by the advance of genetics depends upon what reconciliation society chooses to make between the ancient antinomies--social obligations as against individual rights and reproductive freedom and privacy as against the requirements of public health and welfare."

Kitcher, Philip. The Lives to Come: The Genetic Revolution and Human Possibilities. New York: Simon & Schuster, 1996. 381 p.

Asking whether one will be able to maintain a self-image as increasingly genetic discoveries inform us about the body and the brain, Kitcher discusses the consequences of the genetic revolution. He wonders whether there will be future class systems distinguished by genes or plans for generations to combine certain genes making life a product whose quality could be monitored. He warns that eliminating one form of suffering may only produce other forms, more terrible.

Kobe, Frank H.; and Mulick, James A. **Attitudes Toward Mental Rtardation and Eugenics: The Role of Formal Education andExperience.** *Journal of Developmental and Physical Disabilities* 7(1): 1-9, March 1995.
The authors studied the attitudes toward mental retardation and eugenics of 37 university students enrolled in a course in the psychology of mental retardation. Results indicated that while students had a significant increase in knowledge about mental retardation, there was no chane in their eugenics attitude scores. Kobe and Mulick say that while legislation is important, attitude change must occur at the individual level.

Kohn, Marek. ***The Race Gallery: The Return of Racial Science.*** London: Jonathan Cape, 1995. 322 p.
Kohn provides background for the eugenics movement in Europe and the United States, and argues that a distorted understanding of genetics and history creates an intellectual climate where racial determinism can thrive. He urges a "science of human diversity" where genetic factors do not raise racial barriers.

Lappe, Marc. **Eugenics: Ethical Issues**. In ***Encyclopedia of Bioethics. Revised Edition.*** Warren T. Reich, ed. New York: Simon & Schuster Macmillan, 1995, pp. 770-777.
Lappe presents scientific considerations, types of eugenics (positive and negative), ethical perspectives, issues affecting women, genetic counseling factors, eugenic components of prenatal diagnosis, legitimating genetic policies and application of ethical principles to eugenics. Lappe's entry also includes reference to related articles in the Encyclopedia as well as a bibliography.

Ledley, Fred D. **Distinguishing Genetics and Eugenics on the Basis of Fairness.** *Journal of Medical Ethics* 20(3): 157-164, September 1994.
Using Rawls theories of justice, Ledley applies principles of fairness to genetic interventions. He claims these principles are "incompatible with negative eugenics which would further penalize those with genetic disadvantage." He defends positive eugenics saying these practices are designed to benefit those who have the least advantage, furthering "a system of basic equal liberties."

Lubinsky, Mark S. **Scientific Aspects of Early Eugenics.** *Journal of Genetic Counseling* 2 (2): 77-92, June 1993.
Lubinsky discusses biometry, a school which applied statistics to biology blending inheritance and continuous traits, which he says was part of the early eugenics movement. Mendelian eugenics came from the application of reductionist genetics to human problems with differences seen as primarily genetic, single gene effects. He sees this re-emerging in the reductionism of the Human Genome Project which "may make older eugenic ideas tempting once again."

Marchese, Frank J. The Place of Eugenics in Arnold Gesell's Maturation Theory of Child Development. *Canadian Psychology* 36(2): 89-114, May 1995.
Calling Gesell one of the most important figures who studied child development, the author thinks that Gesell's early work "reveals sympathies with eugenic ideas" but that as challenges to the eugenics movement grew, Gesell "deemphasized eugenic ideas."

Marks, Jonathan. ***Human Biodiversity: Genes, Race, and History*.** New York: Aldine de Gruyter, 1995. 321 p.
Anthropologist Marks consigns two chapters in his work: one to the eugenics movement and the other to racial and racist anthropology, offering background material as well as explanations of various eugenic theories.

Muller, Hermann J. **Human Evolution by Voluntary Choice of Germ Plasm.** *Science* 134 (3480): 643-49, 8 September 1961.
Noting that the term eugenics was in disrepute following the atrocities of World War II, Muller says "a set of hard truths and of genuine ethical values concerning human evolution...cannot be permanently ignored or denied without ultimate disaster." He comments on voluntary contraception, and then suggests artificial insemination by donor or "germ-cell choice" as a means of having offspring of chosen genetic material if parents "elect to depart from that haphazard method" (conventional reproduction).

Nelkin, Dorothy; and Lindee, M. Susan. ***The DNA Mystique: The Gene as a Cultural Icon.*** New York: W. H. Freeman and Company, 1995. 276 p.
The authors analyze the manner in which the double helix has grasped the public's imagination, affecting both institutional and public policy, and as well as being perceived by individuals as an explanation for personality, violence, behavior, and other traits. They ask if the "DNA mystique portend(s) a `new eugenics' - a dangerous science that locates solutions to social problems in biological controls?" Calling eugenics literature from 1900 to 1935 "vast", they cite various important works and explore the popular culture of DNA, saying that in many respects it functions "as a secular equivalent of the Christian soul."

Neuhaus, Richard John, ed. ***Guaranteeing the Good Life: Medicine and the Return of Eugenics.*** Grand Rapids, MI: William B. Eerdmans Publishing Co., 1990. 360 p.
Neuhaus writes that the return of eugenics is evident in technologies such as artificial insemination, in vitro fertilization, embryo transfer; gene therapy, fetal and anencephalic tissue transplantation. He includes euthanasia and and other death with dignity issues in his list of the new eugenics. The book includes ten essays which were given as papers at a conference held at the Center on Religion and Society in New York.

The New Genetics. *Journal of Medical Ethics [Special Issue]* 25(2): 75-214, April 1999.
Eugenics is discussed in seven of the 23 genetics articles in this issue. Daniel Wikler's *Can We Learn from Eugenics* (pp. 183-194) provides a brief historical summary, looking at four "eugenic doctrines" that are not seen as current problems. He argues that the moral challenge now is to "achieve social justice." Other works are: *Preimplantation Genetic Diagnosis and the "New" Eugenics* by David S. King (pp. 176-182); *The Social Nature of Disability, Disease and Genetics: A Response to Gillam, Persson, Holtug, Draper and Chadwick* by Christopher Newell (pp. 172-175); *Prenatal Diagnosis and Discrimination Against the Disabled* by Lynn Gillam (pp. 163-171); *Equality and Selection for Existence* by Ingmar Persson (pp. 130-136); *Should Doctors Intentionally Do Less Than the Best* by Julian Savulescu (pp. 121-126); and *Doctors' Orders, Rationality and the Good Life: Commentary on Savulescu* (pp. 127-129).

Paul, Diane B. *Controlling Human Heredity: 1865 to the Present.* Atlantic Highlands, NJ: Humanities Press International, 1995. 158 p.
Paul says that in the late 19th and early 20th centuries, eugenics were "widely assumed" to be the sensible way to foster breeding favorable traits and discourage less favorable traits. Noting that the movement seemed to disappear after the crimes of the Third Reich, she asks if eugenics has returned in the "guise of medical genetics."

Paul, Diane B. Is Human Genetics Disguised Eugenics? In *Genes and Human Self-Knowledge: Historical and Philosophical Reflections on Modern Genetics.* Robert F. Weir, Susan C. Lawrence, and Evan Fales, eds. Iowa City: University of Iowa Press, 1994., pp. 67-83.
Saying that almost everyone agrees that eugenics is "objectionable" Paul says that it is hard to pin down what is actually meant on any issue. But she thinks that problems in modern genetics are real whether or not one calls these issues eugenics, e.g., the desire for "perfect babies" .

Paul, Diane B. The Politics of Heredity: Essays on Eugenics, Biomedicine, and the Nature-Nurture Debate. Albany, NY: State University of New York Press, 1998. 219 p.
Professor Paul looks at "shifts in the meaning of 'eugenics' and the struggles to demarcate it from genetics," including "motivation (where eugenics is equated with social goals, whereas medical genetics is identified with individual aims) and means (where eugenics is equated with coercion, whereas medical genetics is associated with freedom of choice)."

Pauly, Philip J. Essay Review: The Eugenics Industry--Growth or Restructuring? *Journal of the History of Biology* 26 (1): 131-45, Spring 1993.
Pauly reviews six books on the history of eugenics, noting that the movement arose in many countries and meant different things in each. He suggests that future works must be significantly broader, "encompassing all twentieth-century attention to human biological improvement, however conceived."

Pope Pius XII. Morality and Eugenics: An Address of Pope Pius XII to the Seventh International Hematological Congress in Rome. *The Pope Speaks* 6 (4): 392-400, 1960.
Speaking against sterilization, artificial insemination, and contraception, the pope went on to suggest advice to those afflicted with "Mediterranean hematological sickness." He suggested that physicians could advise patients not to marry (especially kin), or to adopt children rather than reproducing.

Postgate, John. Eugenics Returns. *Biologist* 42(2): 96, 1995.
Postgate writes that thinking about the value of eugenics went "askew" because the basic science needed to approach problems lacked the ability to do so. He discusses germ-line gene therapy and his hopes that it will be fully debated to use the knowledge wisely.

Proctor, Robert N. Genomics and Eugenics: How Fair is the Comparison? In *Gene Mapping: Using Law and Ethics as Guides.* New York: Oxford University Press, 1992, pp 57-93.
Proctor concludes that the potential for abuse of any technology is largely dependent on the social context within which the technology is used. "The danger is that in a society where power is unequally distributed between the haves and the have-nots, the application of the new genetic technologies - as of any other - is as likely to reinforce as to ameliorate patterns of indignity and injustice" (p. 84).

Rifkin, Jeremy. A Eugenic Civilization. In: *The Biotech Century: Harnessing the Gene and Remaking the World.* New York: Jeremy P. Tarcher/Putnam, 1998. pp. 116-147.
Rifkin says that current genetic technologies establish the "foundation for a commercial eugenics civilization." "Genetic engineering technologies are, by their very nature, eugenics tools." He provides a history of the eugenics movement in the United States, indicating that the "new eugenics is coming to us not as a sinister plot, but rather as a social and economic boon."

Sachedina, Abdulazis. Eugenics and Religious Law: Islam. In *Encyclopedia of Bioethics. Revised Edition.* Warren T. Reich, ed. New York: Simon & Schuster Macmillan, 1995, pp. 783-784.
Pointing out that the "idea of eugenics is not well developed in the Islamic world", Sachedina says questions of laws of incest and consanguinity are looked at from the "perspective of moral and social relationships."

Schwartz, Robert. Genetic Knowledge: Some Legal and Ethical Questions. In *Birth to Death: Science and Bioethics.* David C. Thomasma and Thomasine Kushner, eds. Cambridge, England: University Press, 1996, pp. 21-34.
Schwartz warns against the problems occurring when new genetic knowledge is gained, including the dangers of social eugenic policies, particularly since there is "no standard against which one can judge what is health and what is disease." He says statistics will become the criteria and that agreements and expectations will "require intense efforts on everyone's part." He asks how lack of implantation or abortion differ from social eugenics.

Shockley, William. *Shockley on Eugenics and Race: The Application of Science to the Solution of Human Problems.* Pearson, Roger, ed. Washington: Scott-Townsend Publishers, 1992. 292 p.
Pearson has collected William Shockley's writings about his theories of hereditary human intelligence and his belief that the less intelligent were overproducing and the more intelligent, underproducing. Shockley urged that studies be made of heredity, intellectual and demographic trends in order to ensure high intelligence levels.

Smith, J. David. For Whom the Bell Curves: Old Texts, Mental Retardation, and the Persistent Argument. *Mental Retardation* 33(3): 199-202, June 1995.
Smith surveyed textbooks from the first half of this century and notes that most of them accepted eugenicist arguments as if they were scientific facts. He says statements made in The Bell Curve as "beyond significant technical dispute" are in fact still questions of the greatest complexity in human diversity.

Smith, John Maynard. Eugenics and Utopia. *Daedalus* 117 (3): 73-92, Summer 1988.
Smith states that in earlier times the only way to eliminate an undesirable gene from a population was to reduce breeding chances, but that it is now possible to think of genetic change which can be "direct alteration or transformation of particular genes." He calls this "transformational eugenics."

Steen, R. Grant. *DNA & Destiny: Nature & Nurture in Human Behavior.* New York: Plenum Press, 1996. 296 p. Steen reviews genetic behaviorism, supplying a history of the eugenic movement, and discusses the "continual tension between the possible and the actual--the possible determined by the genes, the actual by the environment."

Testart, Jacques. The New Eugenics and Medicalized Reproduction. *Cambridge Quarterly of Healthcare Ethics* 4(3): 304-312, Summer 1995.
Molecular genetics and medically assisted procreation are the new eugenics according to Testart who says that the best test tube embryos will be selected making it "benevolent and learned, painless and efficient."

Tucker, William H. *The Science and Politics of Racial Research.* Urbana: University of Illinois Press, 1994.
Focusing on the issue of race and eugenics, Tucker concludes that there is no scientific purpose or value to the study of innate differences between races. He suggests that such studies have been undertaken to rationalize social and political inequalities as the unavoidable consequences of naturaldifferences.

Wachbroit, Robert. What Is Wrong with Eugenics? In *Ethical Issues in Scientific Research: An Anthology.* Edward Erwin, Sidney Gendin, and Lowell Kleiman, eds. New York, Garland Publishing, 1994, pp. 329-336.
Wachbroit describes traditional eugenics as an effort to select parents and modern eugenics as an effort to select children, or to design them. He questions how one could know what is in the child's best interest or how one can choose for a future generation's good. He concludes that if "genetic diseases are once again held to constitute a public health problem, modern eugenics could very well share the moral collapse of the old eugenics."

Zimmermann, Susan. Industrial Capitalism's Hostility to Childbirth, Responsible Childbearing, and Eugenic Reproductive Policies in the First Third of the 20th Century. *Issues in Reproductive and Genetic Engineering* 3 (3): 191-200, 1990.
Zimmermann holds that the eugenic policies of birth regulation proposed by certain eugenicists in the early part of the century were based on reforming motherhood and individuals to become achievement oriented.

The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain C.1870-1959. Contributors: Mathew Thomson - author. Publisher: Oxford University. Place of Publication: Oxford. Publication Year: 1998. Page Number: 41.

II. EUGENICS - UNITED STATES
Barkan, Elazar. Reevaluating Progressive Eugenics: Herbert Spencer Jennings and the 1924 Immigration Legislation. *Journal of the History of Biology* 24 (1): 91-112, Spring 1991.
Barkan traces the changes in Jennings' attitudes toward eugenics and argues that too great an emphasis has been placed on his egalitarian views during the early 1920s.

Barkan, Elazar. The Retreat of Scientific Racism: Changing Concepts of Race in Britain and the United States Between the World Wars. Cambridge, England: University Press, 1992. 381 p.
Barkan explores the anthropology, biology, and politics of race, thoroughly looking at the development of the eugenics movement in Great Britain and the United States. Saying that eugenics was a "synthesis between social and scientific views, he describes the various men whose ideas promulgated eugenics.

Dowbiggin, Ian Robert. Keeping America Sane: Psychiatry and Eugenics in the United States and Canada 1880-1940. Ithaca, NY: Cornell University Press, 1997. 245 p.
Psychiatrist Dowbiggin looks at "why and to what extent did psychiatrists actually endorse eugenics? How responsible were they for eugenic laws?" He analyzes the careers and works of prominent psychiatrists practicing and teaching in the early years of psychiatry, and concludes that they meant well embracing popular eugenic ideas in an age of "progressivism." He notes that virtually all psychiatrists of this era expressed "an opinion favorable toward eugenics."

Eugenics Makes a Comeback in the U.S. *Bulletin of Medical Ethics* 100: 6, August 1994.
Recent developments in welfare and population control in New Jersey, Arizona, Nebraska, Connecticut and Florida are described briefly. In Colorado, prison sterilizations have been proposed as conditions for parole, and in South Dakota, Medicaid will pay for the insertion, but not the removal of Norplant contraceptive for welfare women.

Gallagher, Nancy L. *Breeding Better Vermonters: The Eugenics Project in the Green Mountain State.* Hanover, NH: University Press of New England, 1999. 237 p.
The author, in the course of her graduate research, discovered the records of the Vermont Eugenics Survey which collected responses of Vermont government and medical authorities to questions about eugenical sterilization. In addition to identifying alcoholics, epileptics and illiterates as candidates for surgery, the records also showed that the local tribe of Abenaki Indians were targeted for sterilization.

Gardella, John E. Eugenic Sterilization in America and North Carolina. *North Carolina Medical Journal* 56(2): 106-110, February 1995.
Tracing North Carolina's eugenic sterilization laws, Gardella describes the Eugenics Board of North Carolina (established in 1933) whose jurisdiction was limited to the mentally ill and the feeble-minded. Noting opposition by the Catholic Church and

others, he says that sterilizations virtually ceased after World War II. He goes on to warn against resurgence of behavioral genetic eugenics and approaching social problems from a "simplistic biological perspective."

Gillies, J.D.; and LeSouef, P.N. Towards a Better Human: The Mark 2 Human Genome: A Word of Advice from Us Down Here. [Humor.] *BMJ: British Medical Journal* 311(7021): 1669-1676, 23-30 December 1997.
Illustrated by children's drawings of possible future "improved" humans, various scientists imagine how humankind could be redesigned. Evolutionary biologies Stephen Jay Gould concludes that he would "never entrust the faulty product of evolution with the task of revising its own evolved structure."
Gould, Stephen Jay. Carrie Buck's Daughter. In The Flamingo's Smile: Reflection in Natural History. New York: W.W. Norton, 1985, pp. 306-318.
Gould alleges that neither Carrie Buck, (the subject of the Supreme Court case Buck v. Bell) or her daughter were mentally deficient. Gould charges that Buck was sterilized because of her social and sexual deviance as much as her lack of mental acumen.

Gould, Stephen Jay. The Smoking Gun of Eugenics. *Natural History* 100 (12): 8, 10, 12, 14-17, December 1991.
Gould comments on the eugenic chapters in Sir Ronald Aylmer Fisher's 1930 The Genetical Theory of Natural Selection, a work which he says is the abstract and theoretical foundation of evolutionary science. He challenges Fisher's argument that advanced civilizations destroy themselves when the ruling or "better" people have fewer children due to "relative genetic infertility" not by choice. Gould concludes that "the genetic fallacy is generic--and applicable almost anywhere for the common and lamentable social aim of preserving an unfair status quo."

Haller, Mark H. Eugenics: *Hereditarian Attitudes in American Thought.* New Brunswick, NJ: Rutgers University Press, 1963, 1984. 264 p.
Haller writes that some U.S. academics and policy makers became convinced that the genetic characteristics of criminals, the mentally retarded, the mentally disturbed, and the impoverished were the basis for their failings. Haller also concentrates on those scientists and social scientists who applied Darwinian analysis to various racial groups and decided some races were more advanced than others on the evolutionary scale. These scientists, the author says, thought that the presence of some racial groups in the United States threatened the long-run biological "quality" of the population.

Hatchett, Richard. Brave New Worlds: Perspectives on the American Experience of Eugenics. *Pharos* 54 (4): 13-18, Fall 1991.
A concise background of eugenics history is provided by Hatchett who opines that the past experience of eugenics makes it wise to address future uses of knowledge and science's relationship with and responsibility to society. He thinks that the recent eugenic revival has shifted focus from the state to economic utility and a "pale concept of human dignity."

Karp, Laurence E. Past Perfect: John Humphrey Noyes, Stirpiculture, and the Oneida Community. *American Journal of Medical Genetics* 12 (2): 127-30, June 1982.
Having written in exasperation about the "involuntary and random propagation" of the human race, Noyes set out to better the human race through the application of stirpiculture (Latin for race-culture). In the 1840s he created the Oneida Community, in which "complex marriages" were the norm, matings were sanctioned by a committee, and offspring were considered children of all the members of the community. Internal pressures and external law enforcement efforts eventually brought the collapse of the Community in 1881.

Larson, Edward J. Confronting Scientific Authority With Religious Values: Eugenics in American History. In *Genetic Engineering: A Christian Response Crucial Considerations for Shaping Life.* Timothy J. Demy & Gary P. Steward, eds. Grand Rapids, MI: Kregel Pulibations, 1999. pp.104-124.
Larson discusses the role that religion in Louisiana and Alabama played in preventing "sterilization of the feebleminded, the mentally ill, and the deviant." He says that while "genetic research offers great medical potential, our religious heritage must be represented in the political arena as a moral 'check and balance.'"

Larson, Edward J. "In the Finest, Most Womanly Way:" Women in the Southern Eugenics Movement. *American Journal of Legal History* 39(2): 119-147, April 1995.
Larson examines the role of women in state campaigns for eugenic legislation in Alabama, Florida, Georgia, Louisiana, Mississippi, and South Carolina during the first third of this century. He says that "women's clubs vied with medical associations in providing the most ready audiences for eugenicists."

Larson, Edward J. *Sex, Race, and Science: Eugenics in the Deep South.* Baltimore: Johns Hopkins University Press, 1995. 251 p.
Larson looks at the South between 1895 and 1945 when "eugenics doctrines commanded the greatest national influence." He says that the movement was a series of distinct campaigns for state legislation that was race and gender based. He thinks many controversial moral and legal issues rising from the new genetics and medicine remain today.

Ludmerer, Kenneth M. *Genetics and American Society: A Historical Appraisal.* Baltimore, Johns Hopkins University Press, 1972. 222 p.
Ludmerer looks at the social climate from 1905 to 1930 which created a situation in which eugenics played a role in public policy making. He examines genetic theories of the day, and how they were adopted by eugenicists, and finally, Ludmerer demonstrates how the political and social events of the time affected the activities of American geneticists.

Penslar, Robin Levin. Ethics and Eugenics. In her *Research Ethics: Cases & Materials.* Robin Levin Penslar, ed. Bloomington, IN: Indiana University Press, 1995, pp. 72-84.
The author present a background to the eugenic movement in America and discusses three cases raising ethical issues about eugenics: a naval heroism gene, feeblemindedness, and ethical considerations in data collection.

Pernick, Martin S. The Black Stork: Eugenics and the Death of "Defective" Babies in American Medicine and Motion Pictures Since 1915. New York: Oxford University Press, 1996, 295 p.
Pernick chronicles a Chicago surgeon who in the late 1910s let at least six infants that he diagnosed as "defectives" die. He publicized this to journalists, wrote about it and starred in a feature film, "The Black Stork." Pernick links eugenics with mercy killing and with race, class, gender and ethnic hatred, tracing the history of such issues, and bringing them from antiquity to the human genome project debates.

Rafter, Nicole Hahn. *White Trash: The Eugenic Family Studies, 1877-1919.* Boston: Northeastern University Press, 1988. 382
Rafter reviews the eugenic family studies conducted in the United States that were grounds for concluding that some families had inferior genes, which perpetuated certain socially undesirable traits as alcoholism, crime, feeble-mindedness, "pauperism", sexual promiscuity, and even loquacity.

Reilly, Philip R. The Surgical Solution: A History of Involuntary Sterilization in the United States. Baltimore: Johns Hopkins University Press, 1991. 190 p.
Reilly details the rise and fall of involuntary sterilization in the U.S. as a means to prevent "mental defectives" from reproducing. From 1907 until the 1960s more than 60,000 men and women were subjected to court-ordered, involuntary sterilization, often without their knowledge.

Rushton, Alan R. *Genetics and Medicine in the United States 1800-1922.* Baltimore: Johns Hopkins University Press, 1994. 209 p.
In Rushton's discussion of genetics and medicine, he includes the early history of the eugenics movement, and notes that "many physicians permitted their ethical objections to eugenics theories, increasingly embraced by genetics researchers, to color their judgment of the research itself." He concludes that the new genetics will help physicians and their patients to govern their lives more effectively. "This is true eugenics."

Smith, J. David. *The Eugenic Assault on America: Scenes in Red, White and Black.* Fairfax, VA: George Mason University Press, 1993. 114 p.
Saying that since 1907, 29 states passed laws mandating sterilization, racial registration and restricting miscegenation (some still in force in the 1980s), Smith chronicles these events and legislation, holding that "the issue of eugenics as potential genocide is even today not dead."

Smith, J. David. *Minds Made Feeble: The Myth and Legacy of the Kallikaks.* Rockville, MD: Aspen Systems Corp., 1985. 205 p.
In 1912 Henry Goddard published a book detailing the story of a New Jersey family he called Kallikak. There were two branches of the family: one branch of "inferior" citizens resulted from a dalliance between the Mr. Kallikak and a nameless, feeble-minded girl he met in a tavern; the other branch came from Mr. Kallikak's later marriage to a respectable woman from a good family. Their offspring became pillars of the community. Professor Smith recounts the details of the study and provides a modern perspective on the theory that mental retardation is a result of tainted blood.

Smith, J. David, and Nelson, K. Ray. *The Sterilization of Carrie Buck.* Far Hills, N.J.: New Horizon Press, 1989. 268 p.
Smith and Nelson relate the 1920s story of Carrie Buck, who was the subject of the U.S. Supreme Court decision Buck v. Bell. Decribed as "poor white trash", teenaged, pregnant and labelled retarded, Buck was involuntarily sterilized after being committed to the Virginia Colony for Epileptics and the Feebleminded.

U.S. Supreme Court. Buck v. Bell. *Supreme Court Reporter* 47: 584-585, 1927.
Carrie Buck was an eighteen year old and resident of a Virginia state home for "mental defectives" at the time her case was heard by the Supreme Court. The daughter of a "feeble-minded" mother, she was the mother of an illigitimate "feeble-minded" child herself (who was conceived when she was raped). The Supreme Court concluded that "It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let the starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind.... Three generations of imbeciles are enough..." (p. 585).

III. EUGENICS - GERMANY

Aly, Götz; Chroust, Peter; and Pross, Christian. *Cleansing the Fatherland: Nazi Medicine and Racial Hygiene.* Baltimore: Johns Hopkins Press, 1994. 295.
Details are provided of German physicians profiting professionally and financially through the Nazi racial hygiene program. Aly, Chroust and Pross reveal stories of the T-4 euthanasia program, and the killing of maladjusted adolescents, handicapped persons, foreign laborers too sick to work, and even German civilians who suffered mental breakdowns during air raids.

Barondess, Jeremiah A. Medicine Against Society: Lessons From the Third Reich. *JAMA: Journal of the American Medical Association* 276(20): 1657-1661, 27 November 1997.
Barondess examines the history of German medicine under National Socialism, finding that a "major lesson from the Nazi era is the fundamental ethical basis of medicine and the importance of an informed, concerned, and engaged profession." He describes the rise of eugenic policies in Germany and how physicians subscribed to the dogmas of Nazi racial hygiene.

Dietrich, Donald J. Catholic Eugenics in Germany, 1920-1945: Hermann Muckermann, S.J. and Joseph Mayer. *Journal of Church and State* 34 (3): 575-600, Summer 1992.
Saying that professional eugenicists developed a sense that medicine was a social function responsible for actively intervening and maintaining a "good" genetic pool, Dietrich notes that although this could have been the antithesis of Catholic thought, two German intellectual Catholic scientists provided theories that would allow Catholics to adapt the problematic, negative eugenic policies of the Nazis.

Franzblau, Michael J. Ethical Values in Health Care in 1995: Lessons from the Nazi Period. *Journal of the Medical Association of Georgia* 84(4): 161-164, April 1995.
According to Franzblau, "racial hygiene" represented mainstream German thinking by the time the Nazi came to power. Physicians acted as expert witnesses and sat on sterilization courts to ensure implementation of all the eugenics laws. "Physicians were involved not only in the selection of those to be killed but in actually implementing the techniques for murders in so-called `healing centers' throughout Germany." He says physicians must not be agents of the state and sees great danger when they give up commitment to the individual patient.

Friedlander, Henry. *The Origins of Nazi Genocide: From Euthanasia to the Final Solution.* Chapel Hill, NC: University of North Carolina Press, 1995. 421 p.
Friedlander traces the rise of racist and eugenic policies in Nazi Germany, citing the growth of research centers focused on eugenics in the Weimar years which served as models for similar later Nazi centers.

Hanauske-Abel, Hartmut M. Not a Slippery Slope or Sudden Subversion: German Medicine and National Socialism in 1933. *BMJ: British Medical Journal* 313(7070): 1453-1463. 7 December 1996.
The author presents evidence that suggests that the German medical community even outpaced the new government in 1933 in enforced eugenic sterilizations. He thinks that the relationship between medicine and the government converged in 1933 Germany and that it is occurring again withconverging medical, government and economic policies.

Kater, Michael H. *Doctors Under Hitler.* Chapel Hill, NC: University of North Carolina Press, 1989. 426 p.
Claiming that German physicians became Nazified more thoroughly and sooner than other professions, the author discusses eugenics as racial cleansing. Kater says that medical schools and their faculties became advocates of racial hygiene early in the 20th Century, urging medical selection to improve and augment a superior race while impeding those thought to be inferior.

Kühl, Stefan. The Nazi Connection: Eugenics, American Racism, and German National Socialism. New York: Oxford University Press, 1994. 166 p.
Drawing comparisons between the American eugenics movement and the Nazi program implemented in 1933 to "improve" the population through forced sterilization and marriage controls, Kühl presents a history of eugenics in the United States which he says led the way in international eugenic theories. He argues that American eugenicists' visits to Germany prior to World War II, influenced, aided, and stabilized the Nazi regime, with racism as the core ideology of both American and German eugenicists.

Lifton, Robert Jay. The Nazi Doctors: Medical Killing and the Psychology of Genocide. New York: Basic Books, 1986. 561 p.
Psychiatrist Lifton interviews German physicians who lived during the Nazi era, and comments that "eugenicizing" became the way to develop a Nazi physician. Saying that early German eugenics had a "tone of romantic excess" Lifton quotes Ploetz' "race was the criterion of value" and German physician-geneticist Fritz Lenz who said "our race is doomed to extinction" without a radical eugenics project.

Michalczyk, John J., ed. Medicine, Ethics, and the Third Reich: Historical and Contemporary Issues. Kansas City, MO: Sheed & Ward, 1994. 258 p.
This published proceedings of a conference at Boston College, presents the history leading to the Holocaust in Germany with discussions of "racial hygiene" and Nazi eugenics. Twenty-one essayists are included along with illustrations of old posters urging Germans to produce only healthy offspring.

Müller-Hill, Benno. Eugenics: The Science and Religion of the Nazis. In *When Medicine Went Mad: Bioethics and the Holocaust.* Pp. 43-52. Arthur L. Caplan, ed. Totowa, NJ: Human Press, 1992.
Müller-Hill defines science as describing the world as it is, not what it should look like, and goes on to relate the background for genetics and eugenics from 1900-1933, pointing out that until the Nazis came into power in Germany, eugenicists had little success in Europe. In the aftermath of the Holocaust, the author holds that medicine and science should never deliver ethical values which must come from other sources.

Müller-Hill, Benno. Murderous Science: Elimination by Scientific Selection of Jews, Gypsies, and Others, Germany 1933-1945. Oxford: Oxford University Press, 1988. 208
With the end of World War I, German "scientific propagandists" (psychiatrists and anthropologists) were devastated by the democratic Weimar Republic and saw Hitler as someone who would recognize their ideas and give them prominence. Müller-Hill provides a detailed account of the alliance between Hitler and scientists by reporting on a number of interviews he conducted with the participants.

Proctor, Robert N. Nazi Doctors, Racial Medicine, and Human Experimentation. In *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation.* George J. Annas and Michael J. Grodin, eds. New York: Oxford University Press, 1992, pp 17-31.
The experimentation carried out by physicians in the Nazi concentration camps should be understood in the context of German militarism and the racial hygiene movement according to Proctor, who says that their science was not apolitical and passive but an integral part of the Nazi program. Racial hygiene was considered as a complement to personal and social hygiene.

Proctor, Robert N. *Racial Hygiene: Medicine Under the Nazis.* Cambridge, MA: Harvard University Press, 1988. 414 p.
Pointing out that science-based technologies can serve "to maintain social order and facilitate the policing of society" (p.1), Proctor says ideologies can obscure the recognition of such control. He explores the place of science under the Nazi regime and focuses on how the scientists, and particularly physicians participated in the Nazi racial policy, calling it "applied biology" (p. 7).

Weindling, Paul. The Survival of Eugenics in 20th-Century Germany. *American Journal of Human Genetics* 52 (3): 643-49, March 1993.
The continued participation of German eugenicists in academics and public policy after World War II is described. Weindling emphasizes the relationship of eugenics to human genetics and provides a glimpse at the activities of many German eugenicists after the war.

Weindling, Paul. Health, Race, and German Politics Between National Unification and Nazism, 1870-1945. New York: Cambridge University Press, 1989. 641 p.

Weindling focuses on the origin, social composition and impact of eugenics on the rapidly industrialising German Empire before World War Two. Biology and medicine took on important roles in the struggle to curb a decline in poulation, and to cure many social ills -- all the while making new powerful careers for physicians and scientists.

Weingart, Peter. German Eugenics Between Science and Politics. *OSIRIS, 2nd Series* 5: 260-82, 1989.
Eugenics combines evolutionary theory and a theory of human heredity to focus political concerns about population policy and control, according to Weingart who holds that both scientists and politicians used eugenics to advance their causes. But only in Germany, he says, did eugenic scientists or race hygienists "form[ed] a coalition with politicians of the conservative and radical right."

Weiss, Sheila Faith. *Race Hygiene and National Efficiency: The Eugenics of Wilhelm Schallmayer.* Berkeley: University of California Press, 1987. 245 p.
Weiss says that eugenics in Germany was viewed as a "form of rational management or managerial control over the reproductive capacities of various groups and classes." Physician Wilhelm Schallmayer became concerned with "mental defectives" and other nonproductive types and offered biomedical solutions for social and political problems, advocating that the "unfit" be discouraged from marrying and reproducing.

IV. EUGENICS - OTHER PARTS OF THE WORLD
Brobert, Gunnar, and Roll-Hansen, Nils, eds.*Eugenics and the Welfare State: Sterilization Policy in Denmark, Sweden, Norway, and Finland.* East Lansing, MI: Michigan State University Press, 1996. 294 p.
The authors present "case studies of what happened when Denmark, Finland, Norway and Sweden set in place sterilization and eugenics programmes as part of large-scale social welfare experiments based on assumptions that they would contribute to economic prosperity and social progress." They point out that such programmes continued after World War II.

Cairney, Richard. "Democracy Was Never Intended for Degenerates": Alberta's Flirtation with Eugenics Comes Back to Haunt It. *CMAJ: Canadian Medical Association Journal* 155(6): 789-792, 15 September 1996.
Cairney reports a lawsuit against the government of Alberta for wrongful sterilization won by a woman who had been sterilized at age 14 under the Sexual Sterilization Act of 1927 which promoted the theory of eugenics and led to the sterilization of more than 2800 persons. A physician who served on the original sterilization board is quoted as saying that eugenics is in some ways practiced now through prenatal diagnosis and therapeutic abortion.

Canada. Law Reform Commission. *Sterilization: Implications for Mentally Retarded and Mentally Ill.* Ottawa: The Commission, 1979. 157 p.
The Commission examines reasons for sterilizing the disabled, its legality and consent issues raised by sterilization in this working paper. It makes policy recommendations for Canada, and includes the text of fourteen policy statements or legislation on sterilization of the disabled.

Dikotter, Frank. Race as Seed (1915-1949). Chapter 6 in his *The Discourse of Race in Modern China.* London: Hurst & Company, 1992, pp. 164-190.
Calling eugenics a pseudo-science, Dikotter traces the Chinese background of taijiao, a mid-19th Century theory of prenatal education that would look at everything that affected the fetus. He goes on to describe their adoption of eugenics theories which peaked in the 1920s and 1930s, but continued well beyond those years into the 1960s.

Gewirtz, Daniel S. Toward a Quality Population: China's Eugenic Sterilization of the Mentally Retarded. *New York Law School Journal of International Comparative Law* 15(1): 139-162, 1994.
Gewirtz says that while the "quasi-scientific" eugenics movement has fallen into disrepute in the West, it has become popular in China because "population quality" is appealing because it works toward the government's desire to control "population quantity." He presents a thorough discussion of China's policies concerning mental retardation.

Jones, Greta. *Social Hygiene in Twentieth Century Britain.* London: Croom Helm, 1986. 180 p.
The history of British social hygiene organisations such as the Eugenics Society, the National Council for Mental Hygiene, the Central Association for Mental Welfare, the People's League of Health, and the National Institute for Industrial Psychology is provided. These groups were influenced by Social Darwinism, and were based on the assumptions that we need to eliminate the "unfit", and that eugenics would improve the general level of industrial and personal efficiency in the working class.

Macnicol, John. Eugenics and the Campaign for Voluntary Sterilization in Britain Between the Wars. *Social History of Medicine* 2 (2): 147-69, August 1989.
The history of the British eugenic movement is traced between World Wars I and II. While much emphasis has been placed by others on the link between "progressive" thought and eugenics, Macnicols stresses the Labour Party's efforts to quell eugenic legislation. The Eugenics Society campaign to pass legislation on voluntary sterilization of the mental "defectives" was the most significant effort, though the Society's crusade fell short.

Mazumdar, Pauline M.H. Eugenics, Human Genetics, and Human Failings: The Eugenics Society, Its Sources and Its Critics in Britain. London: Routledge, 1992. 373 p
Mazumdar focuses on the Eugenics Education Society in Britain. Founded over fears the "residuum", or "pauper class" was reproducing so quickly that it would be able to stem the tide of natural evolution of the human race, the Society attempted to integrate new scientific and mathematical theories into discussions of public policy and legislation.

McGregor, Alan. Eugenic Thought in France. *Mankind Quarterly* 30 (4): 337-50, Summer 1990.
The author quotes eugenic statements by French authors from 1687 to 1969. He recommends L'Idee Eugenique en France: Essaie Bibliographie by Henry de la Haye Jousselin (Limoges: A. Bontemps, 1989).

McLaren, Angus. *Our Own Master Race: Eugenics in Canada, 1885-1945.* Toronto: McClelland and Stewart, 1990. 228 p.
While sterilization of the "feeble-minded" in British Columbia and Alberta was the most significant effort to stem reproduction of "degenerate" persons, immigration restriction, birth control, mental testing, and family allowances were all suggested as ways to improve Canadian society in the first half of the twentieth Century.

O'Brien, Claire. China Urged to Delay `Eugenics' Law. *Nature* 383(6597): 204, 19 September 1996.
Saying that genetic legislation has a tragic history, scientist's from around the world petitioned the Chinese government to delay the eugenics law which took effect in 1995. Articles cited were the requirement that physicians give advice to couples diagnosed as having genetic diseases considered "inappropriate" for child-bearing and that the couple should agree to sterilization or long-term contraception if they marry.

Pearson, Veronica. Population Policy and Eugenics in China. *British Journal of Psychiatry* 167(1): 1-4, 1995.
Comparing China"s birth policy as reminiscent of the programmes of sterilizations carried out in Germany in the 1930s, Pearson describes the National Marriage Law of 1950 which prohibited marriage in China if one of the parties suffered from mental illness, leprosy or venereal disease; going on to show how subsequent laws stressed eugenics and healthier births. She indicates the goal is fewer but healthier babies; that they view eugenics as a "matter of quality control, devoid of moral implications...."

Redmond, Geoffrey P. Eugenics and Religious Law: Hinduism and Buddhism. In ***Encyclopedia of Bioethics. Revised Edition.*** Warren T. Reich, ed. New York: Simon & Schuster Macmillan, 1995, pp. 784-788.
Redmond says that it is unlikely that there would be any eugenic statements from either religion, but that both Hinduism and Buddhism "have ethical ideas or methods that can be applied to modern problems." He discusses rules that govern Hindu reproduction, and suggests that Hinduism requires a form of eugenics, but that Buddhism is essentially neutral to eugenics.

Roll-Hansen, Nils. Eugenics Before World War II: The Case of Norway. *Pubblicazioni della Stazzioni Zoologica di Napoli* 2 (2): 269-98, 1980.
Norwegian eugenic activities are described, highlighting John Alfred Mjoen and his ®Norwegian Program for Racehygiene¯ and his struggle against Otto Lous Mohr. It is claimed that Norway was the site of some of the earliest public outcry against the scientific community's "dilettantic and irresponsible" ideas.

Schneider, William H. Quality and Quantity: The Quest for Biological Regeneration in Twentieth-Century France. New York: Cambridge University Press, 1990. 392 p.
In a response to the perception that French society was in a state of decline and degeneration, eugenics appealed to some early twentieth Century scientists and policy makers. Birth control, premarital examinations, sterilization and immigration control were adopted in varying degrees as ways to affect the quality of the population, which had to be counterbalanced against fears of a shrinking population.

Soloway, Richard A. Demography and Degeneration: Eugenics and the Declining Birthrate in Twentieth-Century Britain. Chapel Hill: University of North Carolina Press, 1990. 443 p.

Soloway examines the declining birthrate and family size among the well-educated and successful in Britain at the turn of the century, and the swelling ranks of the less-educated portion of the population. This demographic profile opened the door for the adoption of eugenic thought and Social Darwinism.

Stepan, Nancy Leys. *"The Hour of Eugenics": Race, Gender, and Nation in Latin America.* Ithaca: Cornell University Press, 1991. 210 p.
Stepan examines eugenics in Latin America as a science of heredity that was shaped by political, institutional and cultural factors, and also as a social movement with an explicit set of policy proposals that seemed to eugenicists to be logically formed from hereditarian science. She highlights the history of eugenics in Brazil, Argentina and Mexico, and studies general trends in Latin America.

Suzuki, Zenji. Geneticists and the Eugenics Movement in Japan. *Japanese Studies in the History of Science* 14: 157-64, 1975.
Suzuki outlines the development of eugenic thought in Japan, beginning with the desire for self-preservation of the ex-military class, who declared themselves genetically superior. Other eugenicists interested in westernizing Japanese culture advocated a program of yellow and white intermarriage.

Tomlinson, Richard. China Aims to Improve Health of Newborns by Law. *British Medical Journal* 309 (6965): 1319, 19 November 1994.
Brief details are provided on new Chinese legislation regarding marriage and the prevention of unhealthy births. With an emphasis on healthy babies and mothers, the chinese government requires premarital genetic evaluations, testing for contagious diseases, and is some cases requires persons carrying "serious" genetic defects to agree to sterilization or long-term contraception before obtaining permission to marry.

V. ADDITIONAL READINGS

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Pat Milmoe McCarrick, M.L.S. is a former Reference Librarian at the National Reference Center for Bioethics Literature (NRC), Georgetown University who along with Mary Carrington Coutts, another former reference librarian at the NRC, first prepared the Eugenics Scope Note for publication in June 1995. NRCBL reference staff continue the updates.

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Appendix 1: 1st National Maori Sexual And Reproductive Health Conference

1st National Maori Sexual and Reproductive Health Conference
Wainuiomata Marae, Wellington, Monday 1 November 2004
Opening address by Tariana Turia, Co-leader, Maori Party

E nga iwi o nga hau e wha, tena koutou katoa

As I came to this conference I was thinking about the tangi I attended less than a week ago of one of our whanau from the river.

John Manakore Peina was a good man. A hard-working farmer, a Justice of the Peace, well-respected within the community. A committed Catholic, a leader in our society. A host of officials from various government departments turned up to express their condolescences to the whanau.

And the collective asset base that we will remember him by, literally overwhelmed the humble marae at Kaiwhaiki.

In his last service, his children, his grandchildren, his great-grandchildren were asked to stand at the front of the tent, and be seen.

It was an awesome sight.

The balancing of the intensive depths of a tangi with the therapeutic value of the life before us, made it both agonising and uplifting all at once.

You will all be well aware of the whakatauki, confirming our very existence began as a seed from a place called Rangiâtea.

E kore au e ngaro, te kâkano i ruia mai i Rangiâtea
I shall never be lost, the seed which was sown from Rangiâtea.

In that action of whakatinanatanga, we saw visibly, how from the käkano of John and Hera, and their tupuna before them, developed new lives in their multitudes.

In fact, one of his daughters was due, the day her father was buried.

And as is so often the way, the cycle of life is restored.

I was delighted to accept the honour of speaking at the first national Maori Sexual and Reproductive Health Conference.

And in doing so, I wanted also to honour the contribution that Te Puawai Tapu in particular, has made to the discussion about Maori sexual and reproductive health.

I want to record my appreciation to your members, including the kuia Anne Delamere, Dr Papaarangi Reid, Pania Ellison for the leadership and expert advice you have provided me with over the years.

And we can never gather in a hui like today, without remembering the legacy of our great friend, Dr Irihapeti Ramsden, her tenacity, her courage, and her passion for saying it how it is.
And so too, it is her influence, which guides me when thinking through the implications of work associated with aitanga aria mate, aitanga maru; with safer sex.

The lasting impression from the tangi at Kaiwhaiki will be the wonder and privilege of life.

These are concepts which Dr Huirangi Waikerepuru will celebrate in his address. The knowledge that our origins emerged out of te kore from which came ira atua. In tikanga Mâori terms, ira tangata came from ira atua.

So when we look at the faces of our babies, we recognise the imprints of those before us.

I think of the concept of kawai whakaheke: we are what our ancestors were.

I think of my nannies who would hold my face in their hands, and mihi to our tupuna. Tena koe e te hunga mokopuna.

It's more than DNA.

In looking to reflect the dreams and aspirations of our people, the Maori Party has looked to such concepts as our guiding kaupapa.

Kaupapa such as manaakitanga, whanaungatanga, kaitiakitanga, mana tupuna, and the tikanga that emanate from them. Concepts that our nannies and koroua lived, concepts we can restore to ourselves to set our futures.

It's in cherishing the special status that befalls you when you move into the Nanny category. When I sit with our kuia and koroua at hui, they don't ask me how much I paid my cleaner, or what's the size of my pay packet? Their interest is in how many mokopuna we have.

And similarly, my heart just bursts when I disclose we have 6 children, 24 mokopuna, 5 mokopuna tuarua.

It's not a numbers game …..but then again, it is disappointing to read that statisticians state the annual growth rate of the Maori population is projected to slow from 1.4% in 2002 to 1.2% in 2021.

The statisticians tells us that the age structure of the Maori population will undergo change reflecting, amongst other factors, our reduced fertility.

What this will mean for instance, is that the demographics of our population start creeping upwards. The number of Maori children aged between 0-14 years as a proportion of the total Maori population will fall from 37% to 30% over the next twenty years.

Maybe one of our policy goals in the Maori Party should be to go forth and multiply! I want to return to this issue of our 'reduced fertility' as a population.

I often think when I read through the statistics telling me that Maori experience gonorrhoea in higher numbers at a younger age than do non-Maori; Maori and especially rangatahi Maori are at greater risk of sexually transmitted infections; the rate of Chlamydia for Maori (at 10.5%) is over two times higher than non-Maori (4.6%); that the tragedy of these statistics is lost when seen only in the context of epidemiological data.

Similarly as new developments in biotechnology occur I question how any discussion of such technologies can be appreciated without guidance from tikanga and matauranga Maori. Our whakapapa must be the context in which all such discussions sit. Our whakapapa is the bridge which links us to our ancestors, which defines our heritage, gives us the stories which define our place in the world. We are te kakano i ruia mai i Rangiatea.

Mana Tupuna helps us know who we are, from whom we descend, and what our obligations are to those who come after us. And we must celebrate that whakapapa in every heartbeat, every birth and in the lives we have lost.

The expression of our rights defined by Mana Atua, by Mana Tupuna, is best reflected in our drive for rangatiratanga, our self-determined destinies. The survival and the prosperity of our people is determined by the protection of our whakapapa. And I have chosen those words deliberately. Protection, not control.

I am intolerant of the excessive focus on controlling our fertility. When I used to sit around the Cabinet table with colleagues, one of the many hot topics I got into strife about was discussion around the 'problem' of teenage pregnancy.

My objection was to the problemmatization of conception.

Professor Sidney Hirini Mead has discussed how our cosmological beginning as a people, are mirrored in the processes of conception. From the kâkano (seed) develops the koi ora hou (a new life), which - while within the whare tangata (womb) - possesses mauri, whakapapa, wairua, hau and pûmanawa (natural talents). It is then born into the world of light.

So when Cabinet Ministers sat around tut-tutting the fact that the fertility rate for Maori females aged 13-17 years was 26.2 per 1000, more than five times that of non-Maori, (4.9% per 1000), I objected to their analysis of our fertility as a problem.

If there was respect for our existence as based on kaupapa, the foundation principles of the Mäori world, these Ministers may have thought more carefully about the interventions they were seeking to impose. Indeed, their guidance might have been sourced in these words: Ma ratau anake ratau e korero, Ma tatau anake tatau e korero, ehara ma tetahi ake (We will be our own assessors, they in turn will be theirs, it is not for others to judge) I am not saying that we should not be concerned about the impact of STIs, or that indeed that I am opening the doors to a sexual explosion. Quite the opposite.

If we are to actively demonstrate rangatiratanga, to respect wairuatanga, our connections must be affirmed through promoting knowledge and understanding of atua Mäori; and they must be maintained and nourished towards the achievement of well-ness. Tikanga Mâori gives us clear cultural guidelines about how we treat one another and how the human body is regarded.

Whether it's medical intervention that is considered such as hormonal replacement therapy or hysterectomy, or some other form of intervention such as depo-provera, inter-uterine devices, or some other form of contraception, there are guiding principles to understand our obligations to respect all attributes of human life as tapu.

It's not a textbook science, but it is in understanding our responsibilities for protection, for nourishment, for respect for te whare tangata. Implicit in our kaupapa is the reality that we are all children of our ancestors entering this world through the whare tangata that is woman. Such a precious gift is not meant to be the responsibility of one person, alone.

In the matter of pregnancy, manaakitanga will tell us that care must be placed on the life within – but also conscious of the need to ensure the mother's health is not placed in jeopardy. The expertise and support of inter and intra whanau, hapu and iwi relationships must be called on for support. As descendants of ira atua, we are part of an inter-related universe. Our strength is collective. As part of this the concepts of vertical and horizontal care that include the roles of grand parents and siblings may need to be actively restored.

Tino rangatiratanga is about revitalising and reminding ourselves of the rights, the responsibilities and obligations that exist within whanau.

We need to retain the essence of who we are, to celebrate that, and to focus on promoting the importance of oranga wairua for Mäori well-being. If we nourish and nurture respect for whanaungatanga, if we ensure protection of te whare tangata, we will truly be demonstrating our belief that our people are our wealth. Na reira, kia kaha koutou ki te whai o koutou moemoea, mau ki to tino rangatiratanga.

Kia kaha koutou, ki te tu, kia kaha, kia kaha.

Appendix 2: Ministry Of Health (2002). An Indication Of New Zealanders' Health

Ministry of Health (2002). "An Indication of New Zealanders' Health: Public Health Intelligence Occasional Report No 1" page xi.

Indicator	Current level	Variation within population	Trend	International comparison
Socioeconomic factor				
Unemployment rate	5.2% of adults available for, and actively seeking, work (September 2001)	**Higher for Mäori**	Improving since 1991	Approximate median of OECD
Environmental factors				
Drinking-water quality	86% of population served with compliant water (2000)	People living in areas with smaller water supplies (usually rural areas) are less likely to have adequately monitored drinking water	Improving	Not available
Water fluoridation	62% of population receive fluoridated water (2001)	Low in Northland, Wanganui, Nelson Marlborough, West Coast, Canterbury, and South Canterbury, high in Waitemata, Auckland, Tairawhiti, Capital and Coast, and Hutt	Not available	Not available
Risk factors (biological)				
Obesity	Males 15% Females 19% (1997)	**High for Mäori and Pacific people**	Increasing	Not available
Prevalence of diabetes	Males 4.1% Females 3.3% (1997)	**High for Mäori and Pacific people, and for people living in deprived areas**	Increasing	Not available
Prevalence of high blood pressure	Males 11% Females 12%	**High for Mäori and Pacific people**	Appears to be improving since 1980s	Not available
Mean total blood cholesterol	5.7 mmol/L for both males and females (1996/97)		Not available	Not available
Prevalence of high blood cholesterol (> 6.5 mmol/L)	Males 23% Females 24% (1996/97)	**Mäori males and NZ European/ Other females**	Not available	Not available
Risk factors (behavioural)				
Prevalence of smoking (youths, 14–15-year-olds)	Males 16% Females 22% (at least weekly smoking, 2001)	**High for Mäori, Pacific youths, and females**	Improving since 1999	Similar to Australia, lower than for many European countries, but higher than for the US
Prevalence of cigarette smoking (15+ years)	Males and females 25%	**High for Mäori, Pacific people and females in Wanganui region**	Stable	Higher than Sweden, USA and Finland, lower than Norway and Netherlands
Physical activity level	67% of adults are physically active (1997)	Adult females have lower physical activity levels than adult males	Not available	High physical activity levels compared to other countries
Adequate vegetable	42% of adults consumed	**Mäori, Pacific people, and**	Not available	Not available

Indicator	Current level	Variation within population	Trend	International comparison
and fruit consumption	adequate quantities of vegetables and fruit (1997)	**those living in deprived areas**		
Mean percent dietary energy intake from total fat	35% of energy intake (1997)	**Slightly higher for Mäori**	Not available	Not available
Mean percent dietary energy intake from saturated fat	15% of energy intake (1997)		Not available	Not available
Estimated alcohol consumption per adult	8.9 litres of pure alcohol per adult (2001)	This information is a national total, so no information regarding distribution	Slight increase since 1997	Moderate to low
Quantity of alcohol consumed by youths on a typical occasion	18–19-year-olds Males 8 drinks Females 6 drinks (2000)	Higher for males	Increasing	Not available
Outcomes – Whole of life				
Independent life expectancy	Males 64.6 years Females 67.9 years (1996/97)	**Lower for Mäori, males**	Not available	Not available
Life expectancy at birth	Males 75.7 years Females 80.8 years (1998–2000)	**Lower for Mäori, Pacific people and males generally**	Improving	Approximately median of OECD
Disability requiring assistance	11.4% (1996/97)	Dependent disability increases with age	Not available	Not available
Smoking-attributable mortality	Males 22% Females 14% (1998)	High for males includes Wairarapa, Southland, and Hutt DHBs. High for females includes Lakes, Northland, Wanganui, Bay of Plenty and Wairarapa DHBs	Improving for males, generally deteriorating for females although slight improvement since 1994	Not available
Alcohol-related (primary cause) mortality rate	Males 4.2/100,000 Females 1.4/100,000 (1998)	**High for Mäori**	Improving for males, increasing for females in mid-1990s	Not available
Outcomes – Infants				
Infant mortality rate	5.4/1,000 live births (1998)	**Higher for Mäori, Pacific people, and those with low socioeconomic status**	Improving gradually	Similar to Australia, better than UK and US, but worse than many European countries
Percentage of low birthweight births	6.4% of live births (1999)	**Higher for Mäori**	Generally increasing since 1993	Not available
Full breast feeding at 3 months	51% (1999/2000)	**Lower for Mäori and Pacific people**	Stable since 1994	Not available
Burns hospitalisations (0–4 years)	Males 1.6 per 1000 Females 1.0 per 1000 (2000)	**High for Mäori, Pacific people, and those living in deprived areas**	Improving	Not available
Falls hospitalisations (0–4 years)	Males 7.7 per 1000 Females 5.7 per 1000 (2000)	No consistent variation by ethnicity or deprivation	Increasing	Not available
Poisonings	Males 2.6 per 1000	High for European/Other and	Generally	Not available

Indicator	Current level	Variation within population	Trend	International comparison
hospitalisations (0–4 years)	Females 2.2 per 1000 (2000)	those living in deprived areas	decreasing	
Outcomes – Children				
Whooping cough notifications and hospitalisations (< 5 years)	Notifications 4.7/1000 Hospitalisations 1.2/1000 (2000)	**High for Mäori and Pacific infants**	2000 was epidemic year	Not available
Measles notifications and hospitalisations (< 15 years)	Notifications 0.07/1000 (2000) Low number of hospitalisations		2000 was non-epidemic year	Not available
Meningococcal disease notifications and hospitalisations	Notifications 0.14/1000 Hospitalisations 0.14/1000 (2000)	**High for Mäori and Pacific people**	Fluctuating at high levels since 1997	Not available
Hearing failure at school entry (at 5 years)	7.7% (1998/99)	**Higher percentage hearing loss in Mäori and Pacific five-year-old students**	Improving	Not available
Mean number of missing or filled teeth (at 12 years)	An average of 1.6 missing or filled teeth	**More teeth missing or filled in areas with non-fluoridated water. Worse oral health also for Mäori, and to lesser degree Pacific students**	Stable since 1997	Worse than Australian students' oral health
Percentage caries free (at 12 years)	44% of students were caries free (1999)	**More teeth missing or filled in areas with non-fluoridated water. Worse oral health also for Mäori, and to lesser degree Pacific students.**	Improving since 1994	Worse than Australian students' oral health
Injury mortality (0–15 years)	Males 15.5 per 100,000 Females 7.4 per 100,000 (1998)	**High for Mäori, Pacific people, and those living in deprived areas**	Decreasing	High
Outcomes – Youths				
Teenage fertility rate (15–19 years)	27.9/1000 (2001)	**High for Mäori**	Decreasing	High
Youth suicide (15–24 years)	Males 38.5 per 100,000 Females 13.3 per 100,000 (1998)	**High for Mäori**	Stable since the mid-1990s, with a decrease in the male rate for 1999	High
Youth motor vehicle accident mortality (15–24 years)	Males 36.3 per 100,000 Females 16.7 per 100,000 (1998)	**High for Mäori, Pacific people, and those living in deprived areas**	Decreasing	High
Rheumatic fever notifications and hospitalisations (< 30 years)	Notification 0.08/1000 Hospitalisations 0.08/1000 (2000)	**High for Mäori and Pacific people**	Hospitalisations generally decreased, but increased in 2000	Not available
Outcomes – Adults				
Ischaemic heart disease mortality	Males 158 per 100,000 Females 75 per 100,000 (1998)	**High for Mäori, Pacific people, and those living in deprived areas, and for males in the Southland DHB region**	Decreasing	High
Lung cancer incidence	Males 43.5 per 100,000 Females 24.6 per 100,000 (1997)	**High for Mäori, Pacific people, and those living in deprived areas plus males in Southland DHB and females in Northland**	During the last five years, lung cancer incidence in the 25-44- year age group	Lung cancer incidence higher than USA, but lower than many European

Indicator	Current level	Variation within population	Trend	International comparison
		DHB region	appears to be stable or decreasing	countries
Colorectal cancer mortality	Males 25.7 per 100,000 Females 19.2 per 100,000 (1998)	High in European/Other and males in Wanganui DHB region	Decreasing mortality in the 25–44 age group for both males and females	High incidence compared to OECD countries
Melanoma mortality	Males 6.6 per 100,000 Females 4.0 per 100,000 (1998)	High in European/Other	Decreasing mortality in the 25-44-year age group since the 1980s	Not available
Cervical cancer mortality	3.2 per 100,000 (1998)	**High for Mäori, Pacific people, and those living in deprived areas**	Decreasing mortality in the 25–44 age group since the 1990s	High incidence compared to OECD countries
Breast cancer mortality	25.2 per 100,000 (1998)	High in Counties Manukau DHB region	Stable mortality since the mid-1990s for the 45–64 age group	Approximate median incidence of OECD countries
Tuberculosis	Notifications 0.09/1000 Hospitalisations 0.07/1000 (2000)	**High for Mäori and Pacific people**	Stable	Not available
Outcomes – Older ages				
Prostate cancer mortality	23.2 per 100,000 (1998)	**Although diagnosed at a higher rate in European/Other, mortality rates are higher for Mäori and Pacific people**	Mortality rate in 45–64 age group appears stable following decreases in mid-1990s	High
Stroke mortality	Males 43 per 100,000 Females 42 per 100,000 (1998)	**High for Mäori, Pacific people, and those with socioeconomic disadvantage**	Mortality decreasing	Moderate to low
Falls-related hospitalisations (65+ years)	Males 15 per 1000 Females 23 per 1000 (age 65+ years, age-standardised)	High for European/Other	Increasing	Not available