Te Aka Whai Ora
Māori Health Authority

E112

Background document on the Women's Health Strategy

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He tā kakaho e kitea, he tā ngākau e kore e kitea.

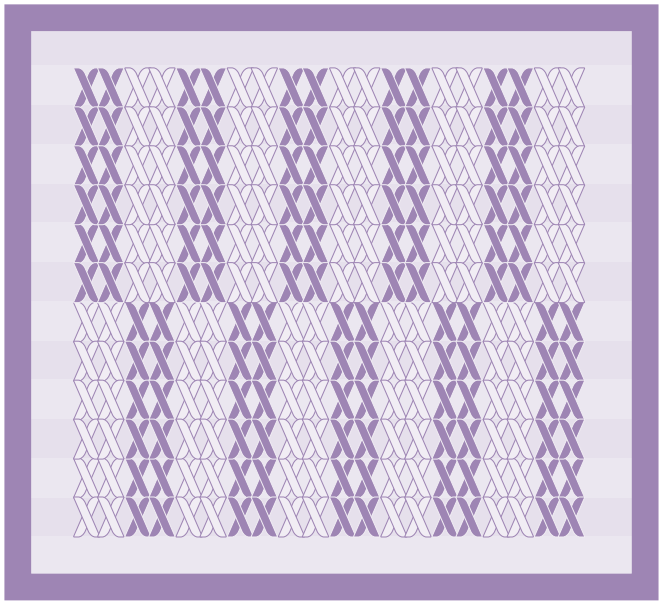
A bend in the reed can be seen,
a bend in the heart cannot be seen.

Executive Summary

Why this paper has been produced

The Pae Ora (Healthy Futures) Act 2022[1] requires the Minister of Health to develop a Women's Health Strategy, to guide health entities in improving health outcomes for women. When preparing a health strategy, the Minister must "have regard to any advice from the Māori Health Authority"[1].

Te Aka Whai Ora has developed this background paper to inform Te Aka Whai Ora's advice to the Minister on the Women's Health Strategy. This paper starts with the expectation of te mana o te wāhine. It contains an assessment of the current state of health outcomes and the performance of the health sector for wāhine Māori. It also positions this evidence in the context of the causes of the causes of health inequities for wāhine Māori and proposes key issues and recommendations that should be included in a Women's Health Strategy.



Roimata Toroa - Tears of the Albatross

Positioning

This paper centres Māori women's health needs and rights to inform Aotearoa New Zealand's (NZ's) overarching Women's Health Strategy. In doing so, this paper foregrounds the Indigenous rights of Māori women that are reaffirmed by te Tiriti o Waitangi alongside the long-standing and significant health inequities experienced by Māori wāhine within NZ.

This paper draws upon mātauranga Māori understandings of wāhine Māori in terms of definitions and social contextualisation that reflect both traditional and contemporary Māori realities. Understanding te āo Māori concepts of the role and power of wāhine Māori allows for strengths-based positioning that is anchored within traditional Māori values and worldviews.

This paper also draws upon the evidence base documenting inequities between Māori and non-Māori wāhine using quantitative and/or qualitative data where available. Kaupapa Māori research and epidemiology principles outline how this evidence base can be used to support a strengths-based positioning for wāhine Māori[3,4]. Historical misuse of data and research to undermine Māori Indigenous rights and realities is specifically rejected. Rather, the application of high-quality research methods and evidence framed from a Kaupapa Māori lens, is analysed within this report to inform te Aka Whai Ora's positioning.

Te mana o te wāhine

Te mana o te wāhine symbolises and defines the status, power and authority of Maori women[5]. Te mana o te wāhine is embedded within a Māori worldview and celebrated within Māori creation narratives. In a traditional Māori worldview, there was balance between the intrinsic value of men and women, both reliant on each other for survival, and both contributing to the collective wellbeing of whānau, hapū and iwi. The historical insult and ongoing impacts of colonisation have distorted contemporary understandings of the power and role of wāhine Māori within Māori (and non-Māori) society. Perpetuated by the low status of women under English law, the silencing of female leadership within Māori culture (to align to English notions of male superiority) and the deliberate destruction of whānau and hapū structures, Maori women were forced into Pākehā models of the nuclear family that left them vulnerable and dependent on male support[6]. Today, Māori women remain marginalised from many Crown processes to provide Māori input into decision-making processes which reflects the ongoing impact of patriarchy across Aotearoa[6]. Colonisation destroyed the balance between Māori wāhine and Māori tāne, making gender a primary determinant of status. A Women's Health Strategy requires actions to redress this imbalance and restore the status and power of wāhine Māori.

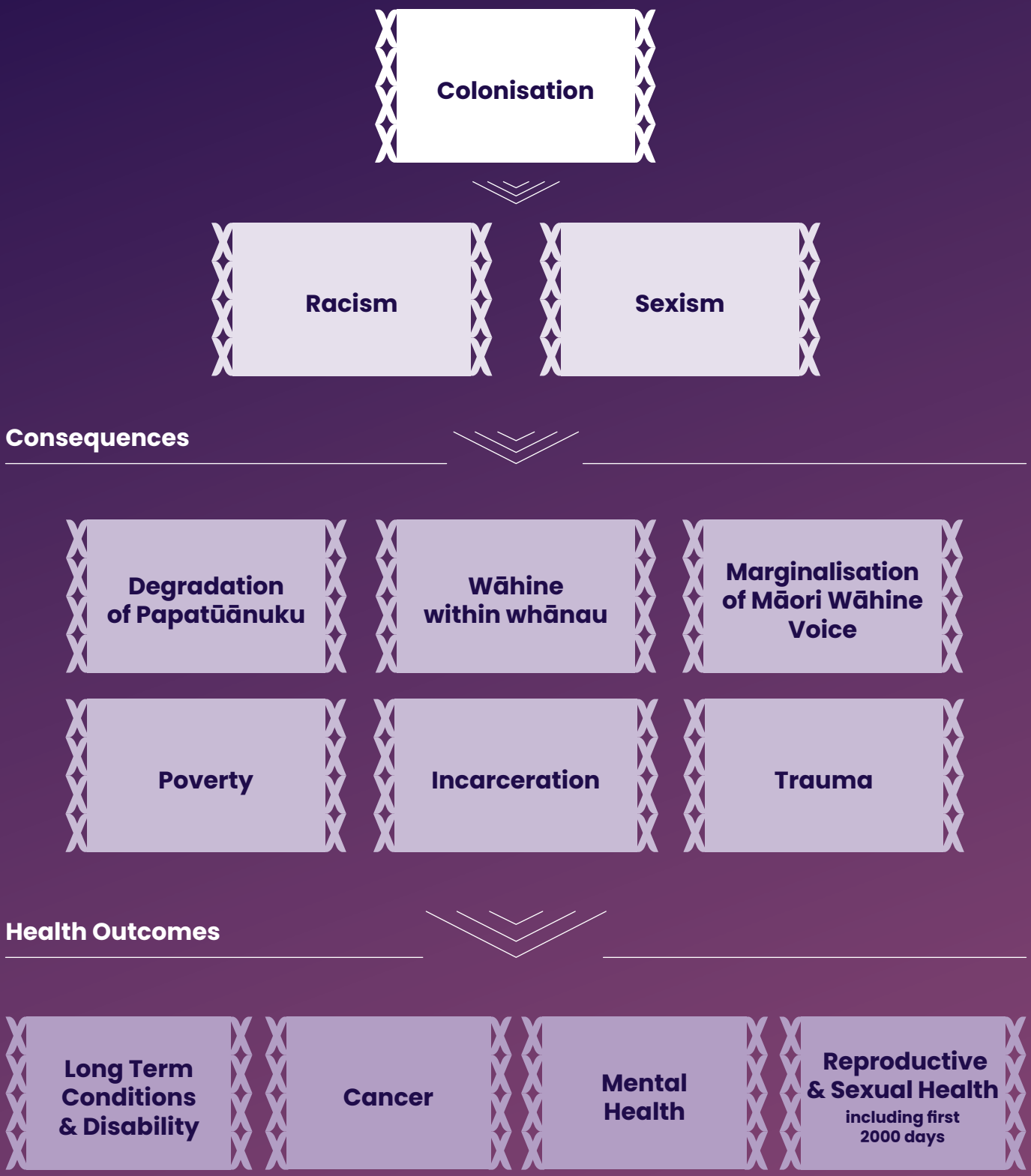
Drivers of health for wāhine Māori

It is impossible to consider health for wāhine Māori without examining and addressing the impact of the root causes of colonisation and its patriarchy. The dual processes of racism and sexism intersect to create and perpetuate the health inequities that wāhine Māori currently experience in Aotearoa. This report highlights some of the most significant consequences and health outcome areas at a population level, that arise as a direct consequence of these upstream causes (Figure 1).

This report seeks to focus the attention of a Women's Health Strategy on the most significant drivers and opportunities for transformation in terms of wāhine Māori hauora. It is not meant to be a comprehensive framework that includes every cause, pathway or outcome. One of the major risks of a Women's Health Strategy is that the key issues for wāhine Māori get lost, diluted or remain unseen in a strategy viewed through the lens of "all women". The priority areas identified in this report build upon health priorities identified by wāhine Māori since the 1980s[5], and align with the Māori health priorities already endorsed by Te Aka Whai Ora[7] and outlined in Te Pae Tata Interim New Zealand Health Plan 2022[8].

We emphasise the causal pathway, to make it clear that downstream health issues cannot be dealt with in isolation without taking into account their origins[9]. The context and causes that lead to, for example, diabetes or health seeking behaviour in wāhine Māori are fundamentally different to non-Māori women, and this distinction is poorly recognised in government policy and health service delivery. Solutions which regard women from a total population perspective will continue to fail to address the specific and unique needs and rights of Indigenous women in NZ.

Figure 1 Causes and consequences with particular relevance to health for wāhine Māori



Recommendations

Overarching recommendations for a Women's Health Strategy, which is Te Tiriti compliant, pro-equity, culturally-safe, anti-racist, and reinforces te mana o te wāhine Māori include:

1. Make the health of wāhine Māori a priority - when we look after the health of wāhine, we look after the whole whānau. The strategy must not view or prioritise issues through a total population lens of "all women". Important health priorities and causes of inequity for wāhine Māori will be missed.

2. Effectively addressing the inequities in health conditions or services for wāhine Māori requires considering and addressing the context of trauma, racism, poverty and marginalisation. Wāhine Māori require different solutions and responses for the same issues.

3. The strategy must consider the most significant causes of health inequities for wāhine Māori, and avoid a narrow focus on female-specific health issues. The primary causes of health inequities for Māori women lie beyond this narrow framing, and a women's health and wellbeing strategy must ensure a comprehensive view of the drivers and opportunities to improve wellbeing for Māori women across the life-course. This includes addressing gendered poverty, trauma & violence, the prevention & treatment of chronic non-communicable diseases, promotion of mental health, as well as ensuring world leading access to sexual and reproductive health.

4. Racism, sexism, classism and other dimensions of marginalisation (including discrimination against disabled and LGBT+ people) intersect for wāhine Māori, which intensifies health inequities and marginalisation. Data is either analysed by sex, or by ethnicity, but not by both, which makes the poor performance for wāhine Māori invisible and unaccountable. Data on health services, health outcomes, and determinants of health must be analysed through a gendered ethnic lens.

This report summaries the evidence for each of the ten major consequences and health outcome areas in more depth and presents recommendations for the focus areas which must be included in a Women's Health Strategy, for it to have a meaningful impact on the health of wāhine Māori.

Next steps

This background paper has been developed internally, based on review of published evidence, testimony and available data. There are a range of external Māori experts and wāhine stakeholders who would add value to this kaupapa and be able to provide the Government with more detailed advice regarding the next steps for each priority area. We also note with anticipation the findings of the Waitangi Tribunal Mana Wāhine claim, and their findings will further inform the direction for Government.

Contents

Introduction

The Pae Ora (Healthy Futures) Act 2022[1] requires the Minister of Health to develop a Women's Health Strategy. The purpose of the Women's Health Strategy is to provide a framework to guide health entities in improving health outcomes for women. The Women's Health Strategy must:

1. Contain an assessment of the current state of health outcomes for women and the performance of the health sector in relation to women; and

2. Contain an assessment of the medium and long-term trends that will affect the health of women and health sector performance; and

3. Set out priorities for services and health sector improvements relating to the health of women, including workforce development.

However, the legislation states that these three points above "do not limit what may be included in the Women's Health Strategy"[1]. When preparing a health strategy, the Minister must "have regard to any advice from the Māori Health Authority"[1].

A Women's Health Strategy must ensure a comprehensive view of the drivers and opportunities to improve wellbeing for Māori women across the life-course – from addressing gendered poverty, trauma & violence, the prevention & treatment of chronic non-communicable diseases, promotion of mental health, as well as ensuring world leading access to sexual and reproductive health. The primary causes of health inequities for Māori women lie beyond the narrow framing of health services, and an approach to address women's health that ignores the interplay/influence of stress, poverty and racism will fail to meet the needs of wāhine Māori, and likely further widen inequities.

When referring to Māori wāhine within this report, inclusive definitions and scope are preferred that allow for anyone who experiences women's health issues to be included regardless of sex or gender (e.g. people assigned female at birth, transgender women). It is acknowledged that some data sources may not adequately reflect this broad scope. Data gaps for inclusive understandings of wāhine Māori will be noted.

This paper is a background paper to inform Te Aka Whai Ora's advice to the Minister on the Women's Health Strategy. This paper starts with the expectation of te mana o te wāhine. It contains an assessment of the current state of health outcomes and the performance of the health sector for wāhine Māori. It also positions this evidence in the context of the causes of the causes of health inequities for wāhine Māori and proposes key issues and recommendations that should be included in a Women's Health Strategy.

Positionality

This paper centres Māori women's health needs and rights to inform Aotearoa New Zealand's (NZ's) overarching Women's Health Strategy.

In doing so, this paper foregrounds the Indigenous rights of Māori women that are reaffirmed by te Tiriti o Waitangi alongside the long-standing and significant health inequities experienced by Māori wāhine within NZ.

This paper draws upon mātauranga Māori understandings of wāhine Māori in terms of definitions and social contextualisation that reflect both traditional and contemporary Māori realities. In doing so, te mana o te wāhine "symbolises and defines the status, power and authority of Māori women"[5]. Understanding te āo Māori concepts of the role and power of wāhine Māori allows for strengths-based positioning that is anchored within traditional Māori values and worldviews. Further detail is provided in the following section.

This paper also draws upon the evidence base documenting inequities between Māori and non-Māori wāhine using quantitative and/or qualitative data where available. Kaupapa Māori research and epidemiology principles outline how this evidence base can be used to support a strengths-based positioning for wāhine Māori[3,4]. Historical misuse of data and research to undermine Māori Indigenous rights and realities is specifically rejected. Rather, the application of high-quality research methods and evidence framed from a Kaupapa Māori lens, will be analysed within this report to inform te Aka Whai Ora's positioning. Key aspects of a Kaupapa Māori approach include:

- Alignment with a 'structural determinants' approach, to critique issues of power, privilege and racism and promote social justice. This report aligns to a 'structural determinants' approach to understand Māori wāhine health inequities as being a result of differential power distribution, the effect of white privilege and the impact of racism in its many forms[10,11]. The 'structural determinants' are the basic and arguably the most important causes of variations in health outcomes for Māori[12-14]. Achieving a social justice agenda for wāhine Māori will require the redistribution of these structural determinants across society[15].

- Acknowledges the impact of colonisation in terms of introducing & maintaining patriarchy. Similar to above, this report acknowledges the historical and contemporary impact of colonisation that both introduced and maintains patriarchy[6] (a social system in which positions of dominance and privilege are primarily held by men).

- Rejection of victim-blame framing. A victim-blaming approach often occurs when poor health outcomes are framed as being a result of poor health behaviour. For example, the Māori 'victims' are 'blamed' for their poor health (i.e. poor health is due to poor Māori behaviour), the notion of individual responsibility is promoted (i.e. Māori just need to change their behaviour) and structural determinants sit outside the analytical frame (i.e. the structure of a non-Māori Western-dominated society is absolved of any responsibility).

- Rejection of cultural deficit framing. A 'cultural-deficit' approach frames poor Māori health as associated with deficits and deficiencies that are internal to Māori 'culture' or are inherent to Māori as a social grouping. As a result of this approach, power imbalances within society remain unframed and unnamed[16]. This approach is not aligned with a structural determinants positioning that critiques white privilege and contextualises the historical and contemporary impact of colonisation on Māori health outcomes (key tenets of a Kaupapa Māori positioning).

- Avoiding cultural-essentialism. In an effort to reclaim space to think from a Māori worldview, mātauranga Māori can be applied in a way that simplifies Māori identity and legitimacy as being an "authentic, homogenous and stable" group identity [17] that is often linked to traditional markers of cultural identity (e.g., the ability to speak Māori and operationalise Māori tikanga)[18]. This has been an important part of the struggle for legitimacy; however, it can result in a failure to acknowledge and expect diverse Māori realities. This has led to a rejection of some Māori for not being a 'real Māori', particularly if they cannot display the markers of 'authentic' Māori culture or knowledge (often as a result of colonising practices) and can also limit the full breadth of interventions available for Māori transformation and health gain. Cultural-essentialism is therefore limiting and should be avoided when considering wāhine Māori health needs that reflect multiple and diverse realities.

- Embracing cultural safety. This report frames 'cultural safety' as being an important solution to achieving health gain for wāhine Māori. Cultural safety requires "healthcare professionals and their associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. This requires individual healthcare professionals and healthcare organisations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided."[19]. Cultural safety therefore encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care to wāhine Māori, as defined by the Māori wāhine and their communities.

Te mana o te wāhine

The role of women in traditional Māori society can only be understood "in the context of the Māori worldview, which acknowledged the natural order of the universe, the interrelationship or whanaungatanga of all living things to one another and to the environment, and the overarching principle of balance"[20].

Mikaere[6, 20] notes that men and women were both essential parts in the "collective whole" forming part of the whakapapa linking Māori people back to the beginning of the world. In a traditional Māori worldview, there was balance between the intrinsic value of men and women, both reliant on each other for survival, and both contributing to the collective wellbeing of whānau, hapū and iwi within traditional Māori society. Quince [21] argues that "te ao Māori was not a patrilineal society traditionally, neither was it matrilineal. It was ambilineal or ambilateral. Meaning it was non-gender specific. Gender was not and never has been the core determinant of status or power within te ao Māori. Mana is"[21]. Rather, as outlined by Simmonds[22] "pre-colonisation, mana wahine and mana tāne existed as complementary parts. The roles of men and women, while distinct, were not mutually exclusive or necessarily hierarchical"[22].

Te mana o te wāhine is embedded within a Māori worldview and celebrated within Māori creation narratives that talk to the power and qualities of deities such a Papatūānuku (the earth mother) and Hineahuone (the first human being) who with the help of the male God Tāne gave the first breath of life. Their daughter Hine-tītama was the dawn maiden, who became Hine-nui-te-pō, the goddess and guardian of the underworld. As Morrison[23] notes "the affirmation of the spiritual power and charisma of women is threaded through our narratives, and our tikanga, as is the natural order and balance of men and women".

Pihama[24] also notes the critical role of tīpuna wāhine within traditional Māori society that includes other important female protagonists such as Mahuika (Māori fire deity, wife of Auahitūroa and grandmother to demigod Māui), Taranga (wife of Makeatutara, mother to Māui) and Murirangawhenua (one of Māui's grandmothers whose jawbone was used to slow the sun and fish up the Ika-ā-Māui, North Island). Although Western orientated interpretations of these stories centre the deeds of the infamous male trickster Māui-tikitiki-a-Taranga – in reality, these tīpuna Māori wāhine represent the powerful and important roles held by wāhine within traditional Māori society.

Mikaere[20] notes that the importance of women is also symbolised by language and concepts expressed through proverbs. Positive concepts are associated with females, such as the description of women as whare tangata (the house of humanity), the word whenua to mean both land and afterbirth, and the use of the word hapū to mean both pregnant and large kinship group. Mikaere asserts that "perhaps the most powerful indication that there was no hierarchy of sexes lies in Māori language, as both the personal pronouns (ia) and the possessive personal pronouns (tana/tona) are gender-neutral"[20]. Prior to European contact, wāhine Māori held many leadership positions throughout Māori society. Prolific writers of waiata tawhito such as moteatea (integral to the maintenance and transmittal of iwi history and knowledge), wāhine Māori are honoured via the naming of hapū and whare tupuna across the country and were often in positions of military, spiritual and political significance.

Despite such a powerful legacy, the historical insult and ongoing impacts of colonisation have distorted contemporary understandings of the power and role of wāhine Māori within Māori (and non-Māori) society.

When the missionaries and early settlers arrived in Aotearoa, they brought with them their culturally specific understandings of the role and status of women[6]. Perpetuated by the low status of women under English law, the silencing of female leadership within Māori culture (to align to English notions of male superiority) and the deliberate destruction of whānau and hapū structures, Maori women were forced into Pākehā models of the nuclear family that left them vulnerable and dependent on male support[6]. Mikaere argues that "one of the most damaging effects of colonisation for Māori women was the destruction of the whānau. It was clear right from the outset that Māori collectivism was philosophically at odds with the settler ethic of individualism. As Māori had their cultural and economic base wrested from them, and as they were ravaged by introduced diseases, their social structures were inevitably undermined"[20].

Today, Māori women remain marginalised from many Crown processes to provide Māori input into decision-making processes which reflects the ongoing impact of patriarchy across Aotearoa[6]. Quince[21] notes how the process of colonisation, where it is assumed a Western worldview is superior to a Māori worldview, destroyed the balance between Māori wāhine and Māori tāne by making gender a primary determinant of status.

Pihama calls for Māori women to reassert their position and status within their communities as well as wider society. She notes "the status of Māori women has been seriously misrepresented. Mana Wahine as a theoretical framework asserts that Māori women must be recognised in the many roles that are ours, and that includes our leadership, rangatira positions. Mana Wahine is an assertion of our intrinsic mana as descendants of our tīpuna, as holders and maintainers of whakapapa"[24].

Similarly, Simmonds articulates that at its core, mana wāhine is about "the intersecting spaces of being Māori and being female; however, it does not exist in isolation but is entangled with mana tāne… colonisation has attempted to disrupt the balance between mana wahine, mana whenua, mana whānau, and mana atua. Mana wahine is but one space within which we can critically analyse the impact of colonisation on all of these institutions – there are many others"[22].

Positioning mana wāhine within the context of te Tiriti o Waitangi, Quince (2022) clarifies that "mana wāhine, is underpinned by Te Tiriti o Waitangi and the promises of tino rangatiratanga under Article 2, and equal citizenship in Article 3. It's about the promotion of mana, the power, authority and influence of women, and the recognition of tikanga and kaupapa Māori, in our laws, our legal processes and institutional structures. The recognition of different familial structures and obligations, our roles and responsibilities in relation to whenua, territory and resources, but also political decision making and power" (p.20).

In considering the concept of mana wāhine, it is important to recognise the diverse realities of Māori wāhine and to avoid culturally-essentialist aligned views on what it means to be a wāhine Māori. In her thesis exploring mana wāhine and atua wāhine, Sharman[25] describes mana wāhine as a framework that was created by Māori women for Māori women. However, she cautions that it is important to avoid potential 'othering' of Māori women. Rather, the framework of mana wāhine should allow Māori women to explore the complexities and differences of their lives where Māori women are not seen as a homogenous group or that there is any 'real' or 'acceptable' Māori woman. (p. 64).

Drivers of health for wāhine Māori

As the above context highlights, it is impossible to consider health for wāhine Māori without examining and addressing the impact of the root causes of colonisation and its patriarchy.

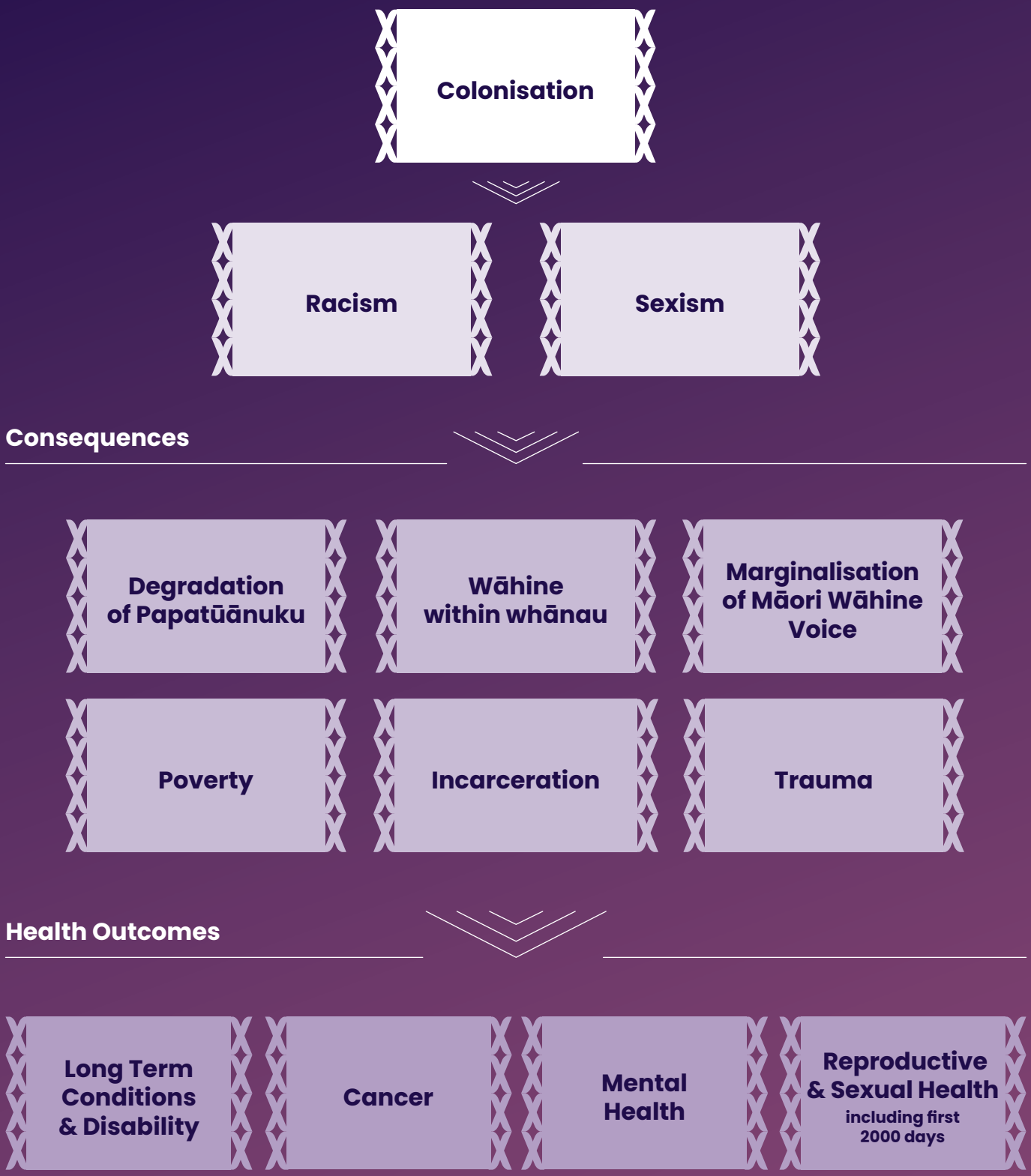
The dual processes of racism and sexism intersect to create and perpetuate the health inequities that wāhine Māori currently experience in Aotearoa.
In Figure 1 below, we highlight some of the most significant consequences and health outcome areas at a population level, that arise as a direct consequence of these upstream causes.

The issues we highlight in Figure 1 are an attempt to focus the attention of a Women's Health Strategy on the most significant drivers and opportunities for transformation in terms of wāhine Māori hauora. It is not meant to be a comprehensive framework that includes every cause, pathway or outcome. One of the major risks of a woman's health strategy is that the key issues for wāhine Māori get lost, diluted or remain unseen in a strategy viewed through the lens of "all women". The priority areas identified in this report build upon health priorities identified by wāhine Māori since the 1980s[5], and align with the Māori health priorities endorsed by Te Aka Whai Ora[7] and outlined in Te Pae Tata Interim New Zealand Health Plan 2022[8].

We emphasise the causal pathway, to make it clear that downstream health issues cannot be dealt with in isolation without taking into account their origins[9]. The context and causes that lead to, for example, diabetes or health seeking behaviour in wāhine Māori are fundamentally different to non-Māori women, and this distinction is poorly recognised in government policy and health service delivery. Solutions which regard women from a total population perspective will continue to fail to address the specific and unique needs and rights of Indigenous women in NZ.

What the diagram does also not show, is the amplification of causes and inequities over the life-course and across generations, both of which have a major impact on the health of wāhine Māori.

Figure 1 Causes and consequences with particular relevance to health for wāhine Māori



Recommendations

Overarching recommendations for a Women's Health Strategy, which is Te Tiriti compliant, pro-equity, culturally-safe, anti-racist, and reinforces te mana o te wāhine Māori include:

1. **Make the health of wāhine Māori a priority - when we look after the health of wāhine, we look after the whole whānau.** The strategy must not view or prioritise issues through a total population lens of "all women". Important health priorities and causes of inequity for wāhine Māori will be missed.

2. **Effectively addressing the inequities in health conditions or services for wāhine Māori requires considering and addressing the context of trauma, racism, poverty and marginalisation.** Wāhine Māori require different solutions and responses for the same issues.

3. **The strategy must consider the most significant causes of health inequities for wāhine Māori, and avoid a narrow focus on female-specific health issues.** The primary causes of health inequities for Māori women lie beyond this narrow framing, and a women's health and wellbeing strategy must ensure a comprehensive view of the drivers and opportunities to improve wellbeing for Māori women across the life-course. This includes addressing gendered poverty, trauma & violence, the prevention & treatment of chronic non-communicable diseases, promotion of mental health, as well as ensuring world leading access to sexual and reproductive health.

4. **Racism, sexism, classism and other dimensions of marginalisation (including discrimination against disabled and LGBT+ people) intersect for wāhine Māori, which intensifies health inequities and marginalisation.** Data is either analysed by sex, or by ethnicity, but not by both, which makes the poor performance for wāhine Māori invisible and unaccountable. Data on health services, health outcomes, and determinants of health must be analysed through a gendered ethnic lens.

The next section of this report reviews each of these ten major consequences and health outcome areas in more depth, and presents recommendations for the focus areas which must be included in a Women's Health Strategy, for it to have a meaningful impact on the health of wāhine Māori.

Process and next steps

This background paper has been developed internally by Te Aka Whai Ora, based on review of published evidence, testimony and available data. The lead authors were Associate Professor Elana Curtis and Dr Belinda Loring, informed by a wider internal rōpu including Dr Maxine Ronald, Dr Jade Tamatea, Ana Bidois, Mamaeroa Merito, Marama Parore, Diane Koti, Tu Williams, Bernadette Jones, Julie Helean, Kristina Marckean, Ngarangi Williams and Denise Lievore.

This report has been developed within a limited period of time (8 weeks) and this timeframe has not enabled extensive consultation across the full breadth of expertise within Te Aka Whai Ora, nor with the rich Māori wāhine expertise outside the organisation.

There are a range of external Māori experts and wāhine stakeholders who would add value to this kaupapa, and be able to provide the Government with more detailed advice regarding the next steps for each priority area. We also note with anticipation the findings of the Waitangi Tribunal Mana Wāhine claim, and their findings will further inform the specific actions for Government.

1. Degradation of Papatūānuku

Rationale

To restore te mana o te wāhine Māori, Papatūānuku (earth mother from whom all things originate) must be nurtured and preserved, and her resources must be maintained and distributed equitably among her descendants[5].

The world is facing unprecedented human-induced degradation of a variety of environmental systems, including pollution of air, water and land, deforestation, mass extinction and climate change[26]. The harmful impacts on human health and wellbeing from climate change and environmental damage is well documented, and Māori are disproportionately at risk[27].

Land-use change and intensification is putting pressure on the unique ecosystems and native species of NZ. In 2022, 94 per cent of reptiles were threatened with extinction or at risk of becoming extinct, and nearly three-quarters of terrestrial birds were threatened or at risk[26]. Human activities are degrading our rivers, lakes, and groundwater. Over 90% of wetlands have been lost, and 60% of the remaining are moderately to severely degraded[26]. Worsening soil quality risks our current food production systems becoming unsustainable. Our climate is warming, glaciers are melting, and sea-levels are rising. In many places in NZ, air pollution levels are above World Health Organisation guidelines[26].

It is not possible to understand or address the impacts of climate change for Indigenous health without acknowledging and confronting colonisation. Colonialism is at the root of the global economic system that fuels anthropogenic climate change and is responsible for the social conditions that limit Indigenous peoples' resilience and adaptation capacity. As Jones notes, human-induced destruction of the planetary systems necessary for life "are not inevitable or human nature but are the result of a series of decisions that have their origins and reverberation in the process of colonisation"[28].

While addressing environmental degradation presents many opportunities to improve health and reduce inequities, there is also significant potential for climate mitigation and adaptation policies to inflict harm on Indigenous peoples[27]. Restoring the mana o te wāhine Māori requires the degradation of Papatūānuku to be prioritised and reversed.

Actions needed

1. Climate actions must be grounded in an understanding of the role of colonisation in exacerbating climate-related health impacts for Māori.

2. Support Indigenous self-determination and recognize Indigenous knowledges as a critical foundation for climate change and environmental health solutions.

3. The health and health promotion system must deconstruct its own policies and practices to avoid reinforcing colonialism and perpetuating inequities.

2. Wāhine within whānau

Rationale

The dislocation of wāhine Māori from their means of extended support through urbanisation and land theft has had devastating effects on Māori whānau[22].

While Māori men were not deemed the equal of their Pākehā counter-parts, they were not subjected to the erosion of their roles and status in the same manner or to the same extent as wāhine Māori[29]. According to Pākehā values, the place for women was in the domestic sphere, sheltered from the male public domain of politics, power and influence. For wāhine Maori, who came from a society where whakapapa and mana were more influential in determining role and status than gender, this was a diminishment of status[29].

The private and isolated nature of the nuclear household was in complete contrast to the open and collective nature of whānau and hapū living. This new dynamic may have contributed to a lack of protection for Māori women against domestic violence, which is not recorded as common in any historical records[29]. As the whānau unit became progressively smaller, the responsibilities of individual women grew, and many young wāhine Māori women now live the effects of the fragmentation and marginalisation of 'whānau' on a daily basis[22]. Wāhine Māori now disproportionately bear responsibility for child-rearing, caregiving for elderly, as mothers, aunties and grandmothers[30]. This is often unpaid voluntary labour further exacerbates the time, stress and financial burden for wāhine Māori[30, 31]. The 'deserving/not deserving' dichotomy in NZ's family support policies mean that parents who are working receive more financial support from the government than parents who are not working (who are more likely to be wāhine Māori, especially sole parents and experiencing multiple dimensions of disadvantage), which further entrenches inequities in poverty for wāhine Māori[32].

The fragmentation of whānau has also impacted on intergenerational knowledge transmission, meaning that some wāhine Māori have a lack of cultural knowledge to express cultural needs to healthcare professionals[33]. The isolation from whenua and support has left wāhine Māori increasingly impoverished, discriminated against by racist and sexist policies and practices relating to employment, health and housing[34]. This in turn has laid the foundations for the trauma, over-criminalisation and poor health experienced by many wāhine Māori.

Whānau is an important site for the future of mana wāhine[22]. A mana wāhine approach would require a reframing and reclaiming of whānau, and empower wāhine by 'reconnecting them to a genealogy and geography that is undeniably theirs'[35]. In addition, whānau discourses ground mana wāhine in the lived - and often stark - realities of Māori women and their whānau and thus require a very practical application of mana wāhine in order to prompt change for better realities[22]. As Smith[36] points out, simply theorising about whānau does not enable better access to culturally appropriate health care, nor does it stop violence and abuse against Māori women and children.

Actions needed

1. Realign NZ's taxation, employment and welfare policies to recognise the enormous social value on the unpaid work of raising children and caring for whānau. This includes:

   a. Implement reforms to Working for Families to increase support for wāhine not in work[37].

   b. Fully implement the recommendations of the Welfare Expert Advisory Group Report[32] to restore dignity and remove the ethnic gender inequity perpetuated through our social welfare system.

3. Marginalisation of wāhine Māori voice

Rationale

The intersections of racism and sexism mean that the voices of wāhine Māori are marginalised within the health system, within contemporary te ao Māori, and in broader society. The role of the state in marginalising mana wāhine voices and knowledges cannot be stressed enough[22].

This marginalisation is even further intensified for wāhine Māori who are disabled, poor, survivors of abuse or incarceration, sole parents, or members of the rainbow community. This challenge for wāhine Māori is exacerbated by the fact that in NZ, equality for women is viewed as a national achievement, a source of pride that NZ is among the world's leading nations[38]. Women's emancipation is seen as a "job done", with some remaining work to be done to close the gender pay gap and increase women on governance board[39]. There is no discussion of women in NZ, particularly wāhine Māori, still having unequal access to basic human rights to food, shelter, education, health (including control over their sexual & reproductive health), justice, economic independence and freedom from violence.

Wāhine Māori experience a number of forms of discrimination, including on the basis of ethnicity, health status, age, income and gender, at higher rates than Māori men[40]. There is increasing evidence that gender bias in health care decision making results in women receiving poorer and slower treatment – this discriminatory treatment is exacerbated for women of colour and for women who are obese[41].

The health system and services are not arranged, funded or delivered with the perspectives and needs of wāhine Māori in mind. This is one of the key reasons they are continuing to perpetuate the inequities in access and outcomes experienced by wāhine Māori. The voices of the most marginalised wāhine Māori are likely to be unheard through standard methods of consultation. It is critical to ensure that a Women's Health Strategy is not biased towards the most privileged majority of women, and fail to improve the health of those in greatest need.

Actions needed

1. The health system must make a deliberate and effective effort to elicit, understand and incorporate the views of the most marginalised wāhine Māori, including but not limited to those who are beneficiaries, incarcerated, sole parents, and living with disabilities.

2. Report key health system performance measures by ethnicity and sex together (not separately by sex or by ethnicity) to ensure that wāhine Māori receive equitable treatment, compared to men and women of other ethnicities.

4. Poverty

Rationale

The causative connection between poverty and ill health is well documented. The overrepresentation of Māori in the most deprived socioeconomic deciles has been diligently reported by the government with no improvement since measurement began in 1991[42].

When indicators of poverty and socioeconomic deprivation are disaggregated by ethnicity and gender, Māori women experience higher levels of hardship than non-Māori males and females, and Māori men, for almost all measures (see Appendix 1, Table 13)[43]. Wāhine Māori are more likely than other groups to be homeless, or living in emergency or overcrowded accommodation[44]. Poverty is frequently and intensely experienced for wāhine Māori who are sole parents – which has detrimental impacts on the health and future wellbeing of their children. Around half of those receiving a sole parent benefit are Māori, over 90% of whom are female[45]. Meeting the requirements to access these essential entitlements is often time-consuming, complex, traumatising and demeaning.

Most government data on socioeconomic determinants are reported by ethnicity, or by sex – making the intersectional amplification of inequities in poverty for wāhine Māori invisible. Policies that have a disproportionately harmful impact on wāhine Māori women are discriminatory – they are sexist and racist and need to be framed not only as an Indigenous rights issue (Te Tiriti & UNDRIP) but as a discrimination against women (CEDAW) issue.

The political framing of "child poverty" as a priority in NZ actively conceals the wāhine Māori behind this largely feminised poverty issue. It is framed this way because of the victim blaming reactions to the true description of "adult and child" poverty. This is disingenuous – it ignores the drivers of poverty for wāhine Māori and prevents an honest discussion of the right solutions. Policies targeted to benefit children in poverty such as cash transfers and housing quality improvements are not in themselves harmful. But by failing to target solutions also at women, opportunities are being missed to lift whānau out of poverty. Successful poverty reduction and female empowerment efforts in developing countries focus on initiatives which seek sustainable and permanent change, empowerment of women through education, skills development, microfinance, access to justice and

quality free child care (as examples). Investing in women has long been recognised as the best investment to improve health. Because NZ is not seeing poverty and health inequity as an empowerment of women issue, NZ's approach is welfare dependency with inadequate pursuit of initiatives which truly seek to empower wāhine Māori to transform their futures.

"Over a two-week period, Miriama was engaging with over 19 different services and support agencies, with this engagement and navigation consuming approximately half of each day. With a different service criterion for each agency, these service requirements all need to be met without access to a vehicle and, as a sole parent, organised around the needs of her dependent children. Resources that many of us take for granted are absent, such as a vehicle, accessible public transport, money to pay for that public transport, internet and printing access to obtain the correct paperwork, and money for the photo identification required by security guards before Miriama is able to even set foot in the door of some services. Even when all preparations are painstakingly made, unexpected circumstances such as illness or not presenting with the "right" information can throw plans into disarray. As a result, seemingly minor mishaps, including missing the bus or running out of phone credit, can have severe consequences, such as benefit sanctions, for whānau."[2]

Actions needed

1. The health system must make a deliberate and effective effort to elicit, understand and incorporate the views of the most marginalised wāhine Māori, including but not limited to those who are beneficiaries, incarcerated, sole parents, and living with disabilities.

2. Report key health system performance measures by ethnicity and sex together (not separately by sex or by ethnicity) to ensure that wāhine Māori receive equitable treatment, compared to men and women of other ethnicities.

5. Incarceration

Rationale

Wāhine Māori are over-represented and discriminated against within the criminal justice system. This includes increasing and disproportionately high rates of incarceration.

Compared to the United States, Canada and Australia, Aotearoa has the highest rate of imprisonment of Indigenous women, and the majority of these wāhine are aged between 16 and 29 years[46]. Two thirds of women in prison, and over half of women on community sentences, are Māori[47]. Wāhine Māori are more likely to be apprehended, prosecuted and convicted of a crime than non-Māori[29].

Wāhine Māori face discriminatory treatment within prison, with as many as 93% of segregations in prison lasting 15 days or longer being of Māori or Pacific women. Concerns have been raised to the Waitangi Tribunal about violence and sexual assault in prison for whakawāhine, takatāpui wāhine or transgender[48]. Concerns have also been raised to the Waitangi Tribunal about high rates of criminal victimisation of wāhine Māori, particularly young wāhine; a failure to identify and prevent risks linked to gang membership for wāhine Māori, and issues around access to justice and appropriate support for wāhine Māori who are victims of crime[48].

Wāhine Māori in prison are a vulnerable population with high and complex needs and requirements. Many come from disenfranchised, socioeconomically disadvantaged communities. The vast majority[47] have been on the receiving end of violence and abuse (including in state settings) throughout their lives, leading to trauma, high mental health needs, alcohol and drug dependency, as well as gender-specific healthcare needs.

It is well documented that the impact of prison on children of imprisoned mothers can be devastating. The imprisonment of Māori mothers, has an even deeper effect: "Māori women have integral roles that they need to play to ensure that the whakapapa is pure and the mokopuna can stand strong. We're already in pain, you put us in prison and the root of that pain goes deeper"[49].

The over-incarceration of wāhine Māori needs to be seen as a fundamental threat to health and wellbeing of Māori wāhine, tamariki and whānau.

Actions needed

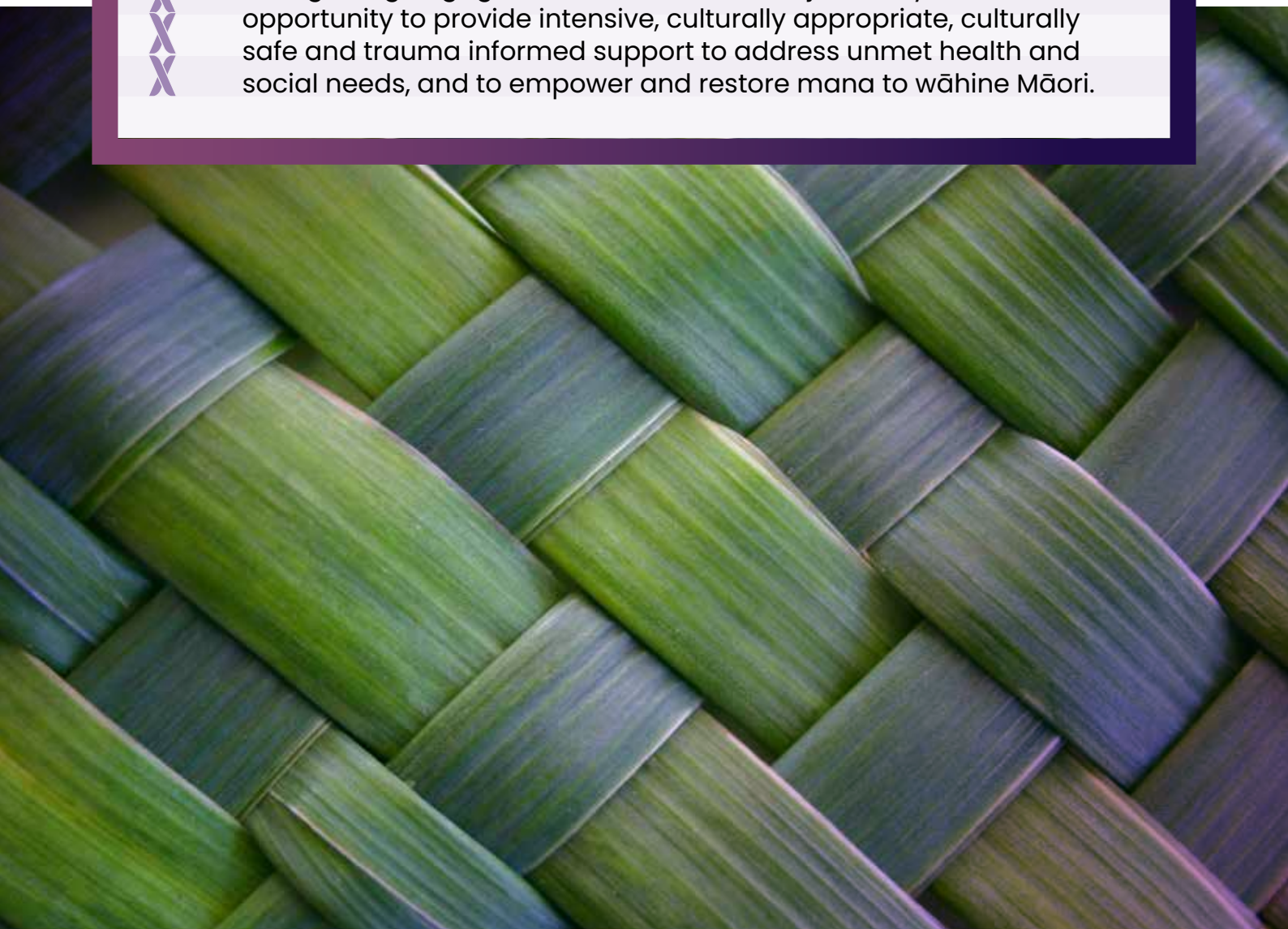
1. Avoid incarceration of wāhine Māori at all costs.

2. Address ethnic bias in criminal justice system which makes Māori more likely to be apprehended, prosecuted and convicted.

3. For those who are incarcerated, actively support wāhine Māori to participate in their critical roles in whānau and as mothers. Prioritising the wellbeing of the children, and whānau functioning in any sentencing decisions. Making women's prisons family friendly and mana wāhine-enhancing.

4. The over-representation of Māori and Pacific women in harsher forms of segregation requires urgent attention as does the development of culturally appropriate and culturally safe programmes including bias training (both implicit and explicit).

5. Recognising engagement with the criminal justice system as an opportunity to provide intensive, culturally appropriate, culturally safe and trauma informed support to address unmet health and social needs, and to empower and restore mana to wāhine Māori.



6. Trauma

Rationale

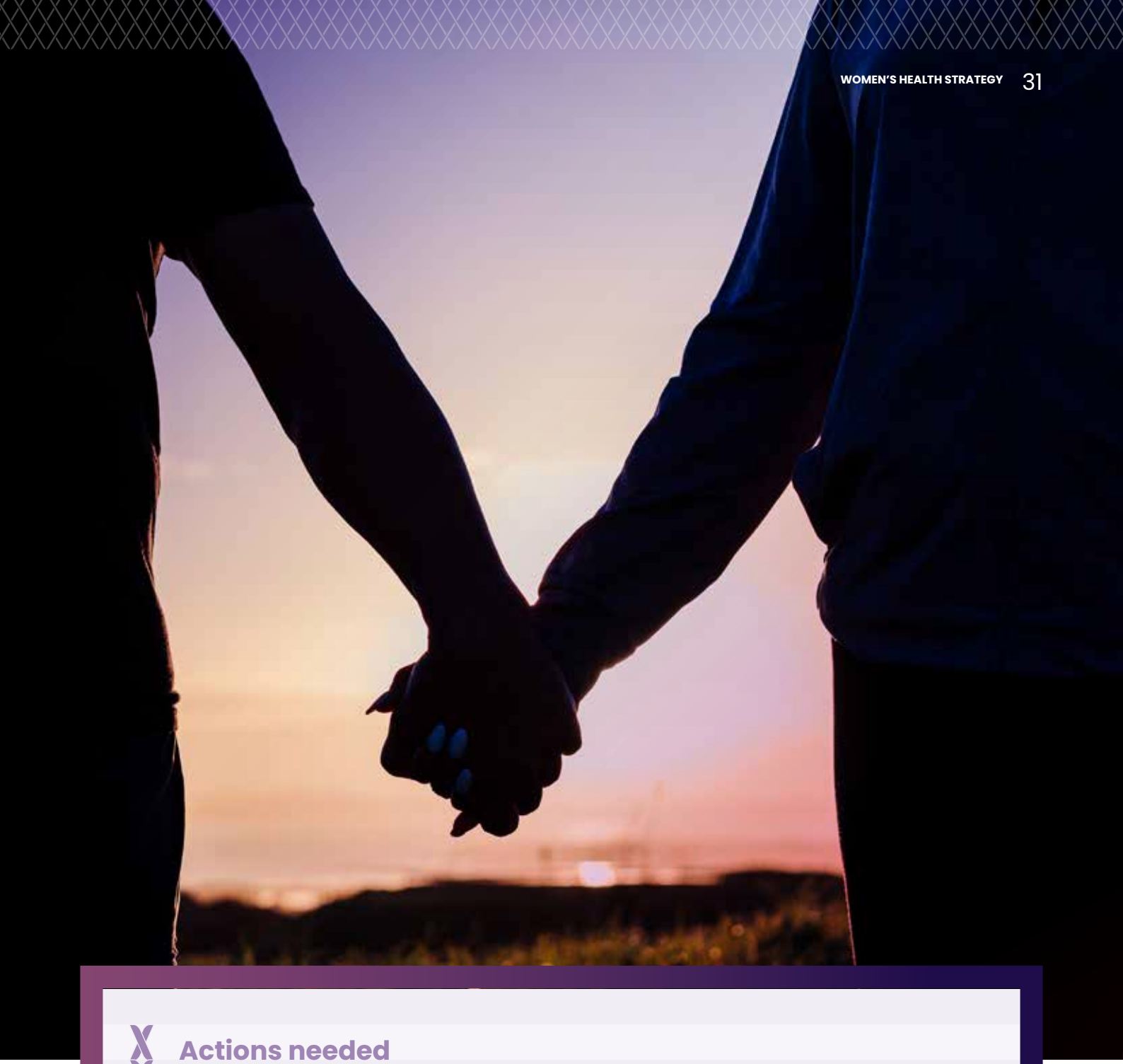
Trauma occurs as a result of violence, neglect, abuse, loss, disaster, historical injustice, and other emotionally harmful experiences. The adverse effects of trauma may impact on mental, physical, social, emotional and spiritual wellbeing, and carry across generations[50].

Many of the causes of trauma for wāhine Māori – including colonisation and patriarchal oppression, racism, marginalisation of wāhine voice, disruption of whānau and culture, poverty and overincarceration, have been discussed above.

Violence and abuse are further downstream consequences of these causes, which contributes significantly to the higher rates of trauma for wāhine Maori. This includes physical and sexual violence, which over half of wāhine Māori experience during their lifetime[51].

Abuse in state settings and wāhine Māori's experience of racism by government agencies, including health services, Oranga Tamariki, and the criminal justice system[48], is another key source of trauma for wāhine Māori that inhibits trust and effective engagement with health care services. Health care settings are often settings where patients feel particularly powerless and vulnerable, especially for those who have experienced abuse and trauma[52,53]. Health and social services which do not apply a trauma-informed approach in designing or delivering services, are often re-traumatising or ineffective for wāhine Māori. Examples where particular improvements are needed for wāhine Māori include the process around ACC sensitive claims, interviewing and examination in public hospital areas, and lack of sensitivity around wāhine who may feel unsafe with male staff.

Many wāhine Māori have experienced multiple sources of trauma, accumulating across generations and over their life-course[54]. Trauma has negative impacts on people's development, health, education, social development and future economic wellbeing, and contributes to a range of poorer physical and mental health outcomes for wāhine Māori. The health system has a key role in preventing and responding better to wāhine Māori who experience gender-based violence. But the health system response needs to go beyond this, to acknowledge the pervasive and harmful context of multiple forms of trauma that many wāhine Māori carry with them, and take a more trauma informed approach to all services for wāhine Māori, including supporting more holistic kaupapa Māori forms of healing and empowerment that draw upon mātauranga Māori[54].



Actions needed

1. A trauma-informed approach in the delivery of all health and social services for wāhine Māori.

2. Preventing violence against wāhine Māori, and improving the support provided to wāhine experiencing violence and abuse.

3. Eliminate further racism and discrimination for wāhine Māori in interactions with the health system.

4. Ensuring the support provided to traumatised wāhine is healing and not itself re-traumatising.

7. Long-term conditions & disability

Rationale

In 2017-19, Māori female life expectancy at birth was 7.3 years shorter, compared to non-Māori females[55].

A handful of preventable non-communicable diseases, including ischemic heart disease, diabetes, chronic lung disease, and stroke are leading contributors to the gap in life expectancy[56]. These long-term conditions are highly preventable, and wāhine Māori experience higher rates of exposure to the leading causes of these conditions, namely tobacco, obesogenic environments, unhealthy diets, and alcohol. These risk factors are strongly patterned by social, commercial and environmental determinants such as poverty, abuse/trauma, social exclusion, and racism, and these influences compound across the life-course, beginning even before birth. Excess bodyweight itself is associated with discrimination, including by health professionals resulting in poorer quality care[57].

Not only is their life expectancy shorter, but wāhine Māori suffer earlier onset of illness, and spend more years in poor health or living with a disability. Wāhine Māori are more likely than non-Māori women, and Māori men, to be in chronic pain[43]. Access to quality health care is also poorer. For example, Māori develop diabetes up to 10 years younger and progress earlier to more serious disease, yet are less likely to receive appropriate HbA1 monitoring and appropriate diabetes-related renal-screening tests than non-Māori[58].

Actions needed

1. Start with interventions that seek to reduce stress (including from poverty, housing insecurity, dealings with government agencies, and violence) and promote the acquisition of skills, resources, and health literacy in wāhine Māori. Interventions to address metabolic risk factors which do not address these more pressing priorities/ health determinants in the lives of wāhine Māori are unlikely to be equitable or effective.

2. There is significant untapped potential in Aotearoa to implement internationally recommended evidence-based interventions on shared risk factors: tobacco, alcohol and unhealthy diet, especially fiscal policies at a population level, which have greatest impact in poorest groups and are most likely to benefit wāhine Māori.

3. Improve access to secondary prevention for wāhine Māori, through integrated interventions that address control of blood pressure, sugars and lipids, body weight, smoking cessation and lifestyle interventions. These must be trauma-informed, culturally appropriate, and based around building skills and capacity to address other key stressors in life, including socioeconomic and safety concerns.

4. Fundamentally redesigning a primary care system which has no barriers for wāhine Māori and delivers culturally appropriate, high-quality care.

8. Cancer

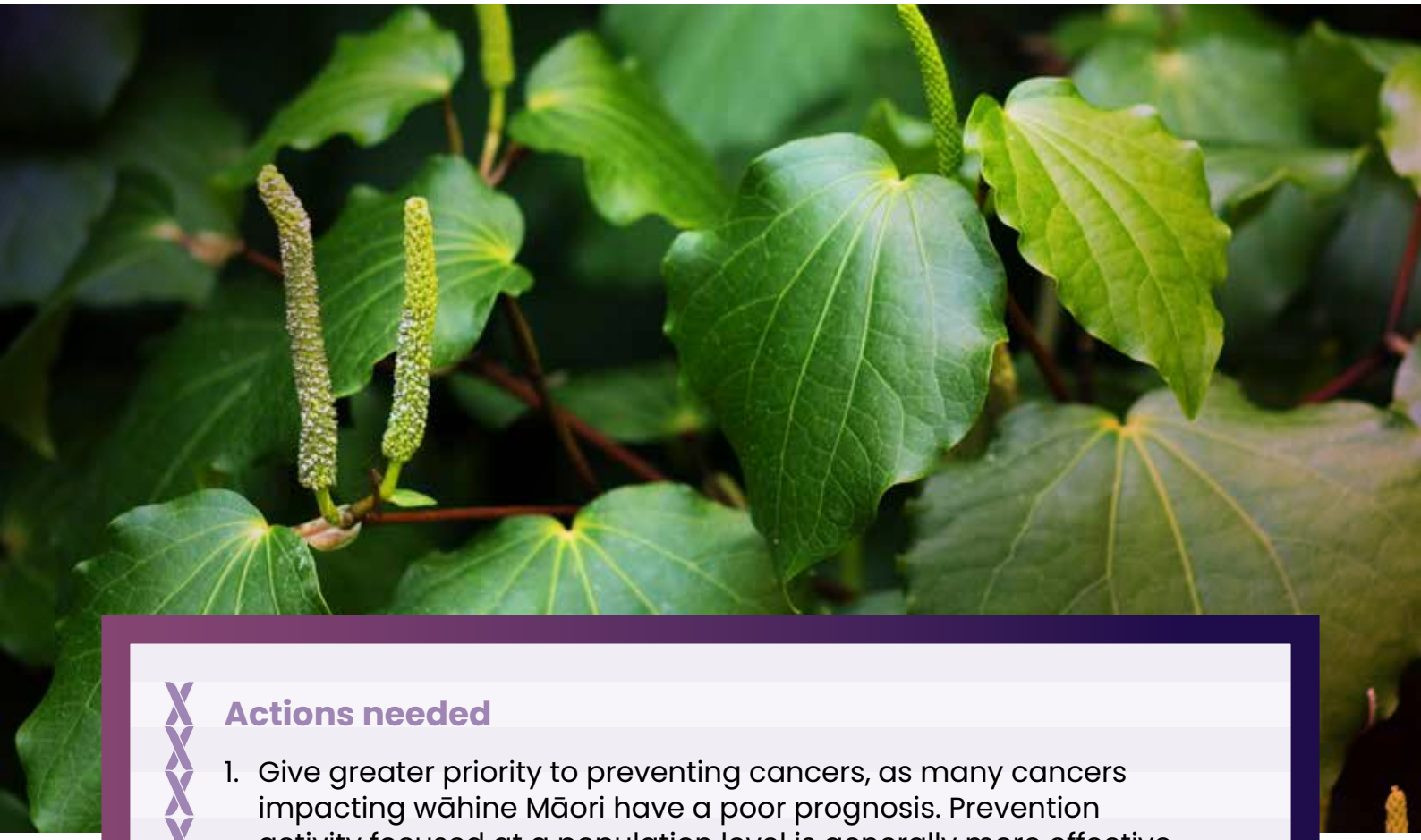
Rationale

Cancer is a leading cause of illness and death for wāhine Māori, making up 25% of amenable mortality. Wāhine Māori women face inequities across the entire spectrum of cancer prevention, early detection and care.

The most significant cancer for wāhine Māori women is preventable and becoming increasingly treatable – for wāhine Māori, lung cancer alone contributes almost 1 year to the life expectancy gap between Māori and non-Māori, non-Pacific women[56]. It is the leading cause of death and years of life lost[56, 59]. Over 1 in 5 Māori deaths are due to tobacco[60] and compared to non-Māori non-Pacific women, a third of the gap in life expectancy for Māori women is due to smoking attributable deaths. A number of promising cancer treatments are available but not currently funded in NZ, despite being available for cancers such as melanoma. Te Tiriti obligations and equity for wāhine Māori need to drive funding decisions for lung cancer.

Breast, stomach, uterine, cervical and liver cancer also make significant contributions to the life expectancy gap for wāhine Māori. Wāhine Māori have some of the highest rates of breast cancer in the world[61]. Wāhine Māori continue to receive less screening for breast and cervical cancers than non-Māori women, and the impacts of COVID-19 have further increased inequities for wāhine Māori. The introduction of HPV self-testing in mid-2023 for cervical cancer is a promising step, but more needs to be done to close the gap for detection of other cancers for wāhine Māori.

Not enough is known about the access and appropriateness of palliative care and pain relief for wāhine Māori[62] and this is an essential component of cancer care.



Actions needed

1. Give greater priority to preventing cancers, as many cancers impacting wāhine Māori have a poor prognosis. Prevention activity focused at a population level is generally more effective, cost-effective and equitable than those that focus on high-risk individuals[63, 64]. This includes:

    a. Tobacco control strategies which are effective for wāhine Māori

    b. Implementing effective policies to protect wāhine Māori from the commercial and environmental determinants of unhealthy diets

2. Improve cancer screening programmes to deliver equitably for wāhine Māori, especially breast screening.

3. Improve equitable access to quality primary care, as most cancers for wāhine Māori are diagnosed outside of screening programmes.

4. Prioritise and fund early detection and life-extending treatments for lung cancer.

5. Ensure access to pain relief and palliative care is equitable and good quality for wāhine Māori.

9. Mental health

Rationale

Wāhine Māori report high levels of psychological distress and mental health challenges across the life-course. Wāhine Māori experience greater stressful life events around the time of pregnancy[65] and suicide is the leading cause of maternal mortality[66].

Anxiety and depression, traumatic brain injury, alcohol use disorders, and schizophrenia are all among the top ten contributors to overall health loss for Māori. The disproportionate impact of addictions, including in Māori men, has a significant impact on the wellbeing of wāhine Māori including through issues such as violence, incarceration, child protection and financial/housing impacts. Wāhine Māori experience poorer mental health care – they are less likely to receive pharmaceutical treatment in relation to need[67], and are more likely to be placed in seclusion[68].

Poor mental health is a consequence of many of the same drivers of other health inequities for wāhine Māori – racism, colonisation, intergenerational trauma, abuse and violence, poverty and cultural disconnection. There is a strong positive relationship between individual mental wellbeing and whānau wellbeing for Māori, and the mental wellbeing of wāhine Māori has lifelong impacts on the wellbeing of their children and whānau.

Action to improve mental health cannot ignore action on the causes of distress in the lives of wāhine Māori lives, and just continue with more programmes to build "resilience" to cope with life stressors which could be removed by social policy changes. At the same time, work is needed to transform mental wellbeing services to meet the needs of wāhine Māori and their whānau.

Actions needed

1. A whole-of-government approach to wellbeing to tackle social determinants of hauora for wāhine Māori, and support activities that impact on multiple outcomes not just mental health and addiction, including poverty, healing from trauma, and building education & skills.

2. In the face of enormous harm to our communities from alcohol and other drug abuse, we need to act on international evidence for effective public health and legislative interventions.

3. Improving access to better quality primary care and strengthening NGOs working with Māori.

4. Urgently complete the national suicide prevention strategy and implementation plan and ensure the strategy is supported by significantly increased resources for suicide prevention and postvention.

5. A genuine te Tiriti partnership with the Mental Health and Wellbeing Commission, including Māori participation in governance arrangements, a partnership between the Commission and Iwi or Māori, and a strong Māori workstream within the Commission.

10. Reproductive & sexual health

Rationale

Maternal mortality is higher for wāhine Māori than any other ethnic group in NZ[66]. Wāhine Māori are almost twice as likely as non-Māori women to experience multiple stressful life events during and after pregnancy[65].

There are missed opportunities to deliver appropriate care and support for Māori women and whānau around the time of pregnancy, which has lifelong impacts for the mother and child. Nearly 50% of wāhine Māori do not have a Lead Maternity Care Giver in the first trimester of their pregnancy[58]. Wāhine Māori are more likely to have gestational diabetes detected in pregnancy, but this is not often connected to follow-up care for the woman after birth to prevent her developing type 2 diabetes. Oral health is a risk factor for poor pregnancy outcomes, and pregnant wāhine Māori experience barriers accessing oral health care in pregnancy, despite having higher needs[69].

Other issues to prioritise include:

- Cost barriers to long-acting contraception
- Higher & increasing STI rates
- Ensuring appropriate supports for teen pregnancy
- Birth injuries & ACC barriers
- Sexual abuse/violence & access to support/ACC
- Lower access to fertility treatment
- Chronic pelvic pain care

Actions needed

1. Improving antenatal and birthing care – including wrap-around support for wāhine hapū (including identifying opportunities to provide longer-term intervention/prevention rather than episodic care e.g. ongoing support to prevent gestational diabetes turning into diabetes, oral health).

2. Whānau orientated interventions providing intensive support for the first 1000 days, that seek to address and minimise stress for wāhine Māori.

3. Removing cost and other barriers to access to sexual and reproductive health services for wāhine Māori.

Appendix 1. Key data on health outcomes for wāhine Māori

Downstream measures of health outcomes

Table 1 summarises the main causes of avoidable death and illness for Māori women, including the contributors to the life expectancy gap, causes of death and health loss and inequities in health loss. The columns for men are presented for comparison.

This table highlights that for Māori women, lung cancer is the leading cause of death and years of life lost. Lung cancer also makes the greatest contribution to the gap in life expectancy between Māori and non-Māori non-Pacific women[56]. Ischemic heart disease comes a close second – it is the second largest cause to the gap in life expectancy gap for Māori women, and the second leading cause of healthy life years lost. Other preventable non-communicable diseases, including diabetes, chronic lung disease, and stroke are also leading contributors to the gap in life expectancy between Māori and non-Māori non-Pacific women.

Table 1 - Leading causes of death, health loss and inequities in life expectancy and health loss for Māori, by sex.

Disease	Wāhine			Tāne		
	Life expectancy gap[a]	Cause of death[b]	Years of life lost[b]	Life expectancy gap[a]	Cause of death[b]	Years of life lost[b]
Ischaemic heart disease	2	2	2	1	1	1
Lung cancer	1	1	1	2	2	3
Suicide				4	3	2
Anxiety and depressive disorders						
Diabetes	3	5		3	4	5
Breast Cancer	6		3			
Chronic obstructive pulmonary disease	4	3	4	6		
Cerebrovascular disease (stroke)	5	4	5			
Motor vehicle accidents				5	5	4
Traumatic brain injury						
Alcohol use disorders						

Source: [a]Compared to non-Māori, non-Pacific women. From Walsh & Grey, 2019[56], [b]Tatau Kahukura, 2015[70].

Notes: This table displays results from separate analyses, and should be regarded as indicative only. It draws from analyses with different methodologies, datasets, year ranges and comparator groups.

1. Mortality

Causes of death

The leading causes of death for Māori are routinely reported by the Ministry of Health in Tatau Kahukura Māori Health Chart Book and can be seen in Table 2 and Table 3. For Māori females, the top five causes of death are lung cancer, ischemic heart disease, chronic obstructive pulmonary disease, cerebrovascular disease and diabetes. If we consider the causes of death which contribute to the greatest number of years of life lost (rather than just the greatest number of deaths), then breast cancer rises up the list to be the 3rd leading cause of YLL lost for Māori females.

In 2006, the Ministry of Health calculated that inequality in health care accounted for approximately 54% of the total Māori–non-Māori mortality inequality for women (adjusted for age)[71]. That is, achieving equity in health care access and quality could make a substantial contribution towards achieving equity in health outcomes for Māori women.

Table 2 - Major causes of death, ranked by age-standardised mortality rates, by gender, Māori and non-Māori, 2010–12

	Males	**Females**
Māori	Ischaemic heart disease	Lung cancer
	Lung cancer	Ischaemic heart disease
	Suicide	Chronic obstructive pulmonary disease
	Diabetes	Cerebrovascular disease (stroke)
	Motor vehicle accidents	Diabetes
Non-Māori	Ischaemic heart disease	Ischaemic heart disease
	Suicide	Breast cancer
	Lung cancer	Cerebrovascular disease (stroke)
	Cerebrovascular disease (stroke)	Lung cancer
	Motor vehicle accidents	Colorectal cancer

Notes: Figures are age-standardised to the total Māori population as recorded in the 2001 Census.

Prioritised ethnicity has been used — see 'Ngā tapuae me ngā raraunga: Methods and data sources' for further information. Source: Mortality Collection Data Set (MORT), Ministry of Health

Source: Tatau Kahukura 2015

Table 3 - Major causes of death, ranked by YLL, by gender, Māori and non-Māori, 2010–12

	Males	**Females**
Māori	Ischaemic heart disease	Lung cancer
	Suicide	Ischaemic heart disease
	Lung cancer	Breast cancer
	Motor vehicle accidents	Chronic obstructive pulmonary disease
	Diabetes	Cerebrovascular disease (stroke)
Non-Māori	Ischaemic heart disease	Ischaemic heart disease
	Lung cancer	Cerebrovascular disease (stroke)
	Cerebrovascular disease (stroke)	Breast cancer
	Suicide	Lung cancer
	Colorectal cancer	Colorectal cancer

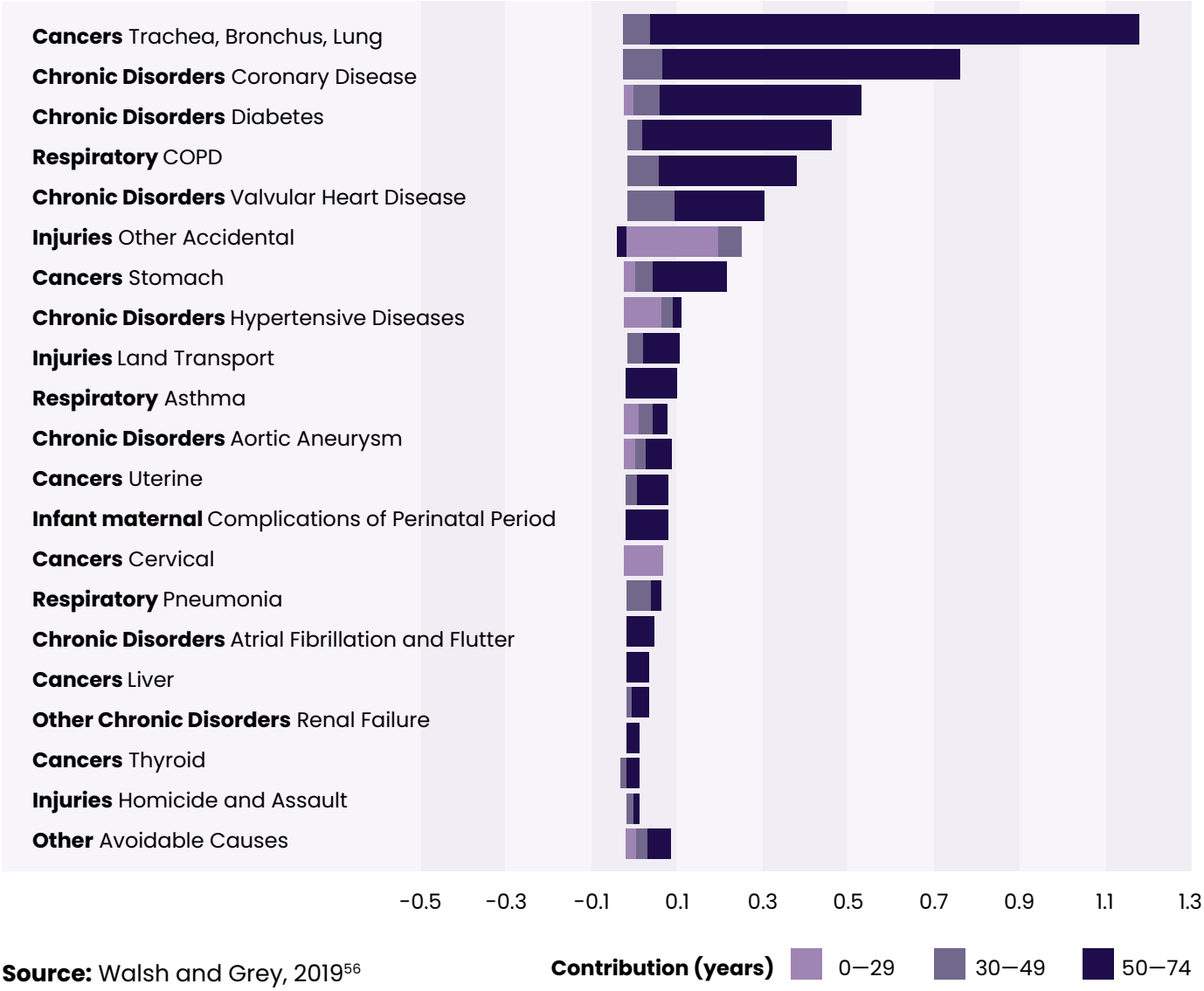
Notes: Prioritised ethnicity has been used — see 'Ngā tapuae me ngā raraunga: Methods and data sources' for further information.Source: Mortality Collection Data Set (MORT), Ministry of Health

Source: Tatau Kahukura 2015

Life expectancy

In 2017-19, Māori female life expectancy at birth was 7.3 years shorter, compared to non-Māori females[55]. A 2019 analysis[56] of contributing causes to the life expectancy gap for Māori compared to non-Māori non-Pacific (Table 4) was highly consistent with the leading causes of overall Māori mortality: lung cancer, heart disease, diabetes, COPD, strokes and breast cancer remain the leading contributors to the life expectancy gap for Māori females.

Table 4 - Decomposition of the life expectancy gap by leading avoidable causes, by age-group, for Māori females



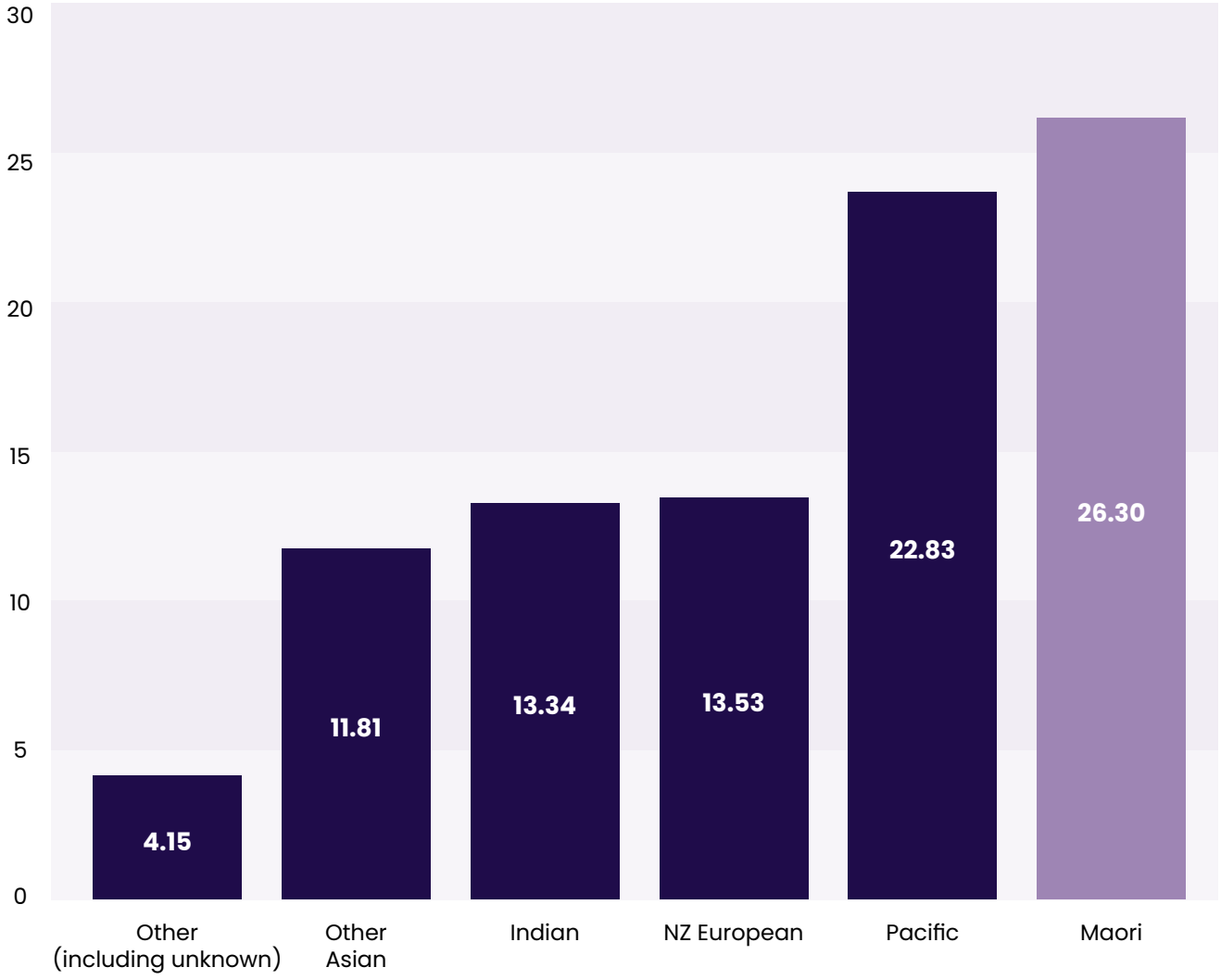
Source: Walsh and Grey, 2019[56]

Another way to examine mortality is to consider the leading causes of the conditions resulting in deaths. One recent analysis for example[60] found that 22.6% of Māori deaths could be attributed to tobacco. Furthermore, they found that compared to non-Māori non-Pacific, 32.9% of gap in life expectancy for Māori women was due to smoking attributable deaths.

Maternal and child mortality

Maternal mortality is higher for Māori than any other ethnic group in New Zealand (Table 5). In 2021, the government's own Perinatal and Maternal Mortality Review Committee wrote in their annual report that "year after year, the Perinatal and Maternal Mortality Review Committee (PMMRC) reports show inequity continues and no significant progress is being made to reduce mortality and morbidity for whānau Māori…"[66].

Table 5 - Maternal mortality ratios (per 100,000 maternities) by prioritised ethnicity, 2006-2015



Source: Dawson et al[72]

2. Morbidity

Measures of morbidity describe what makes us unwell and affect the quality of our lives.

Healthy life expectancy

This is important because data show us that Māori women can expect to live fewer years of their life in good health compared to non-Māori. In 2013, Māori females had a health expectancy of 60.4 years, compared with 67.4 years for non-Māori females.

Disability

Disability survey data is another source of measuring the impact that chronic conditions is having on Māori lives. The most recent figures reported by the Ministry of Health show that for all ages groups except for >65 years, more Māori women than non-Māori women are living with at least one long term disability not alleviated by an assistive device.

Table 6 - Disability prevalence, by age group and sex, Māori and non-Māori, 2013

Indicator Total disabled (of total population), percent, 2013	Māori			Non-Māori		
	Males	Females	Total	Males	Females	Total
0–14 years	19	10.6	14.9	11	7.2	9.2
15–24 years	20.3	23.5	20.9	14	13.8	13.9
25–44 years	24.7	22.2	23.3	14	15.3	14.7
45–64 years	39.6	45.3	43.6	26	26.1	26.1
65+ years	73.7	50	62.2	55.1	57	55.9

Note: Crude rates and prioritised ethnicity have been used - see 'Ngā tapuae me ngā raraunga: Methods and data sources' for further information. Data from: 2013 New Zealand Disability Survey, Statistics New Zealand

Source: Tatau Kahukura 2015

Psychological distress

According to the New Zealand Health Survey, Māori women are 1.28 times more likely than non-Māori women to experience anxiety or depression.

Table 7 - High or very high probability of anxiety or depressive disorder, by gender, Māori and non-Māori, 2013/14

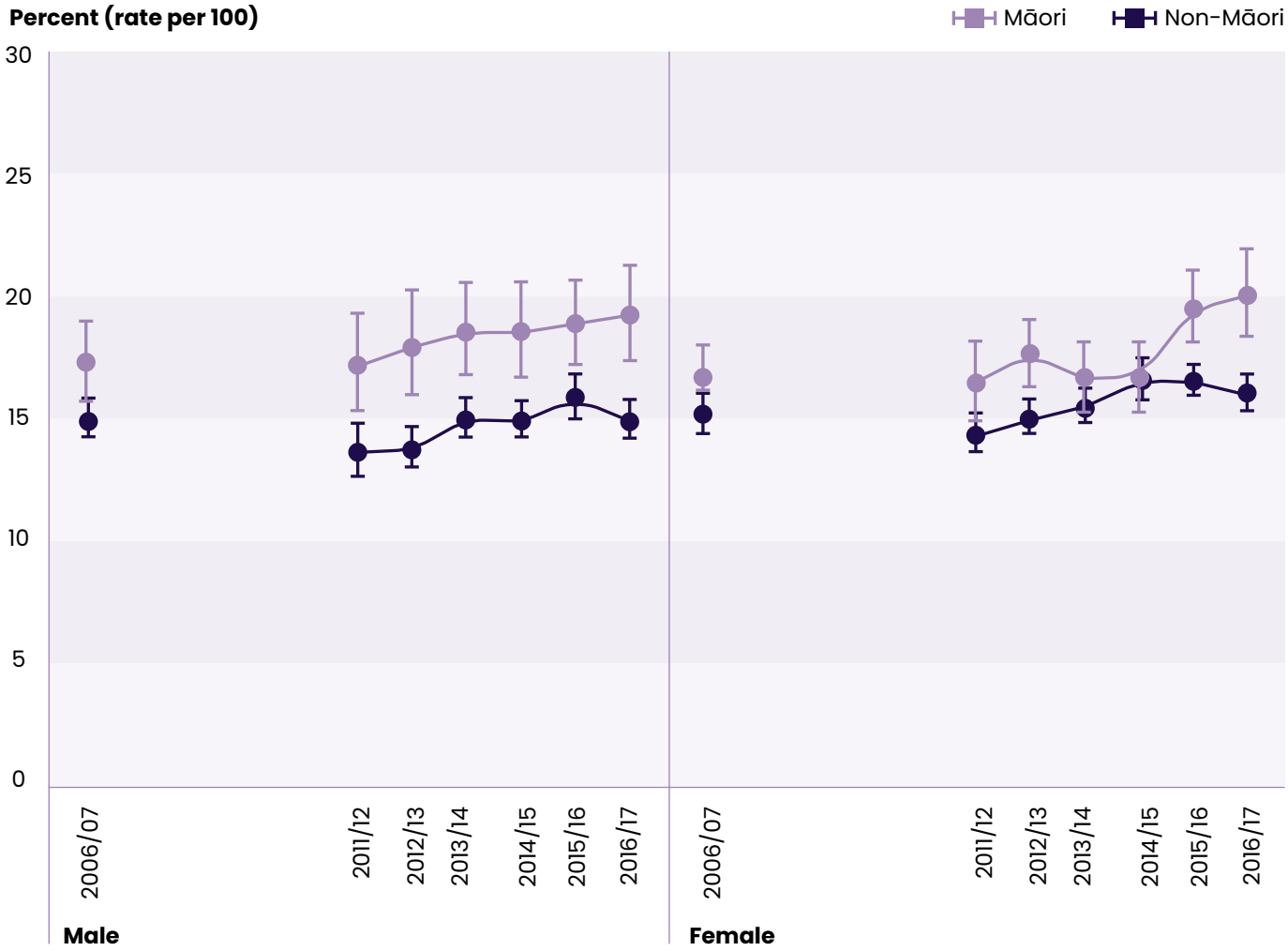
Indicator	High or very high probability of anxiety or depressive disorder, 15+ years, percent, 2013/14		
Māori	Males	9.6	(7.1–13.0)
	Females	9.5	(7.5–11.8)
	Total	9.4	(7.7–11.4)
Non-Māori	Males	4.5	(3.6–5.6)
	Females	7.6	(6.4–9.0)
	Total	6	(5.2–7.0)
Rate ratios (Māori compared with non-Māori)	Males	2.04	(1.36–3.04)
	Females	1.28	(0.98–1.66)
	Total	1.56	(1.24–1.97)

Source: Tatau Kahukura, 2015

Pain

Māori females are more likely to report having experienced chronic pain than non Māori females in 2012/13, 2015/16, and 2016/17 (Figure 3). The difference between the percentage of Māori females experiencing chronic pain compared with non Māori females has increased, particularly since 2015/16[43].

Figure 3 - Experienced chronic pain, 15+ years, by gender, Māori and non Māori, 2006/07–2016/17



Notes: Figures are age-standardised to the 2001 Census total Māori population. Prioritised ethnicity has been used. Source: New Zealand Health Survey (NZHS), Ministry of Health, 2006/07–2016/17.

Upstream measures of causes of health outcomes

1. Health services

The health system performs worse for Māori women at all levels of service delivery, from public health, primary, secondary and tertiary care, and in terms of any dimension of quality measured from accessibility, timeliness, safety and effectiveness. Various measures of health system performance, across health promotion/prevention, early detection, treatment, quality of care highlight priorities for action to address inequities created for Māori.

Prevention & early detection

Māori women are screened for cervical cancer at lower rates than non-Māori women (on average about 10 percentage points lower), and this disparity has not changed for during the last 10 years. Between 2002 and 2017, cervical screening rates of Māori women aged 20 to 69 fluctuated around 64 percent, while the corresponding rate for non-Māori women fluctuated around 74 percent[43]. Māori women are also screened for breast cancer at lower rates than non-Māori women. In 2017, the breast screening rate of Māori women aged 50 to 69 years was 65%, compared to 75% for non-Māori women[43].

Primary care

The MoH reports on measures of unmet need for primary care, based on questions in the New Zealand Health Survey. In the most recent report, Māori adults (RR 1.37, CI 1.27–1.48) and children (RR 1.41, CI 1.21–1.65) were more likely than non-Māori to have experienced unmet need for primary health care in 2013/14[70]. Both Māori adults and children were also more than twice as likely as non-Māori to report not collecting prescriptions due to cost at any time in the last 12 months[70]. Māori females aged 15+ reported the highest percentage of unfilled prescriptions due to cost from 2011/12 (21.3 percent) to 2016/17 (17.7 percent) compared with non-Māori females (8.0 percent in 2011/12 and 8.7 percent in 2016/17)[43].

Avoidable hospitalisations

Avoidable hospitalisations point towards those admissions which could have been prevented through better access to preventative or primary health care. The Ministry of Health defines Ambulatory Sensitive Hospitalisations (ASH) as hospitalisations of people less than 75 years old resulting from diseases sensitive to prophylactic or therapeutic interventions that are deliverable in a primary health care setting (Table 8). Note that ASH rates are likely to be an underestimate as they hide lower access to secondary care for Māori.

Māori women have higher ambulatory sensitive hospitalisations than non-Māori man and women, indicating that Māori women have disproportionately higher unmet need for preventive and primary care.

Table 8 - Health system indicators, by gender, Māori and non-Māori, 0–74-year-olds

Indicator rate per 100,000	Māori			Non-Māori		
	Males	Females	Total	Males	Females	Total
Amenable mortality, 0–74 years, 2010–12	172.1	116.4	142.8	75.2	45.1	59.8
	(164.6–179.8)	(110.6–122.4)	(138.1–147.7)	(73.5–76.8)	(43.8–46.3)	(58.8–60.9)
Ambulatory-sensitive hospitalisation, 0–74 years, 2012–14	3013.4	2987.7	3001.6	1874.7	1776.8	1824.8
	(2978.9–3048.2)	(2954.3–3021.5)	(2977.5–3025.8)	(1863.1–1886.4)	(1765.4–1788.2)	(1813.9–1833.0)

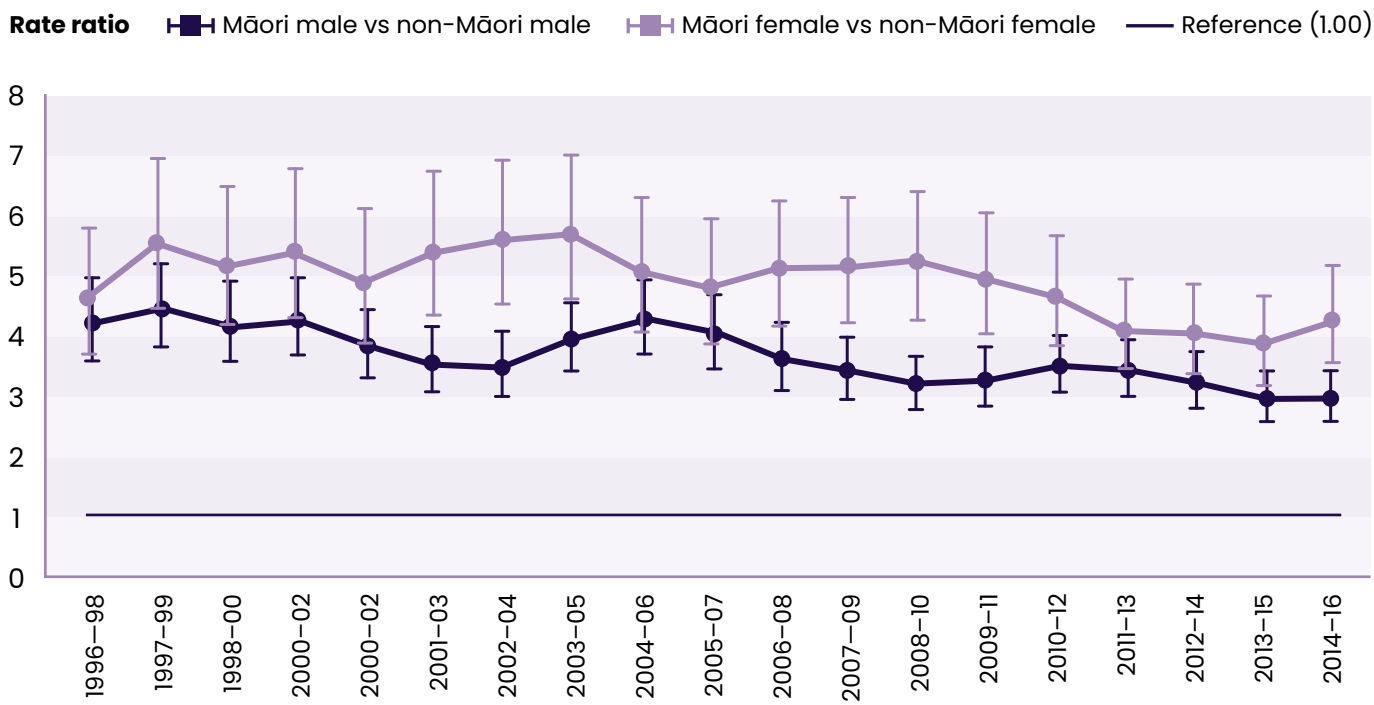
Notes: Figures are age-standardised to the total Māori population as recorded in the 2001 Census.

Prioritised ethnicity. Sources: Mortality Collection Data Set (MORT), Ministry of Health; National Minimum Data Set (NMDS), Ministry of Health.

Quality of care

Another marker of access to appropriate, quality health care is through looking at avoidable complications for condition such as diabetes. Māori females are more likely than non-Māori females to need a leg amputated because of poorly controlled diabetes. The difference between Māori and non Māori females was greater than the difference between Māori and non Māori males over time, even though females had lower rates of lower limb amputation with concurrent diabetes than males (Figure 4)

Figure 4 - Rate ratios of lower limb amputation with concurrent diabetes, 15+ years, by gender, Māori and non-Māori, 1996–98 to 2014–16



Notes: Figures are age-standardised to the 2001 Census total Māori population. Prioritised ethnicity has been used. Source: National Minimum Data Set (NMDS), Ministry of Health, 1996–98 to 2014–16, presented in (43)

Racism in health care

Drawing upon data collected from the New Zealand Health Survey in 2011/12, 4.9% of Māori women reported they experienced unfair treatment by a health professional on the basis of ethnicity, 3 times the rate reported by non-Māori women[43].

Māori women in experience discrimination, exclusion and inequitable access to health care and the social determinants of health. Māori women experience a number of forms of discrimination, including on the basis of ethnicity, health status, age, income and gender, at higher rates than Māori men[40]. In 2011/12, Māori females were more than seven times as likely as non Māori females to have experienced unfair treatment in renting or buying houses because of ethnicity[43].

2. Exposure to health harming risk factors

Tobacco, alcohol, obesogenic environments, diet and physical inactivity

The long-term conditions that form the leading causes of death and disability for Māori women (in particular heart disease, diabetes, cancer, strokes, and chronic respiratory disease) share four priority risk factors. Data on the prevalence of tobacco, harmful use of alcohol, unhealthy diets and physical inactivity are all routinely collected through population surveys and reported by the Ministry of Health (Table 9, Table 10, Table 11, Table 12). These data show that Māori women are disproportionately exposed to all of these major health-harming risk factors, all of which are modifiable by stronger government public health action to ensure equitable access to healthy environments, policies, power and resources for wellbeing.

Table 9 - Current smoking in people aged 15 and over, by sex, Māori and non-Māori, 2013/14

Indicator	Māori			Non-Māori		
	Males	Females	Total	Males	Females	Total
Current smoking (self-reported), 15+ years, percent, 2013/14	41.1	42.7	42	17.9	13.2	15.5
	(36.4–45.9)	(39.5–46.0)	(39.2–44.9)	(16.2–19.8)	(12.0–14.5)	(14.5–16.6)

Notes: Figures are age-standardised to the total Māori population as recorded in the 2001 Census.

Prioritised ethnicity. Sources: Mortality Collection Data Set (MORT), Ministry of Health; National Minimum Data Set (NMDS), Ministry of Health.

Table 10 - Alcohol use indicators, by sex, Māori and non-Māori, 2013/14

Indicator (15+ years, percent, 2013/14)	Māori			Non-Māori		
	Males	Females	Total	Males	Females	Total
Consumed alcohol in the past 12 months	83.1	79.4	80.9	83.4	76.1	79.6
	(80.2–85.6)	(76.9–81.7)	(79.0–82.7)	(81.8–85.0)	(74.5–77.7)	(78.5–80.7)
Drank alcohol 4 or more times a week in the past 12 months (among past year drinkers)	11.9	8.1	9.9	20.4	13	16.9
	(9.1–15.3)	(6.0–10.8)	(8.1–12.2)	(18.8–22.1)	(11.7–14.4)	(15.7–18.1)
Drank large amounts of alcohol at least weekly in the past 12 months (among past year drinkers)	22.7	16.9	19.7	15.1	7.6	11.5
	(19.3–26.5)	(14.7–19.4)	(17.5–22.0)	(13.3–17.1)	(6.4–8.9)	(10.4–12.6)

Notes: Figures are age-standardised to the total Māori population as recorded in the 2001 Census.

Prioritised ethnicity. 'A large amount of alcohol' is defined as more than six (for men) or four (for women) standard drinks on one drinking occasion. Source: 2013/14 New Zealand Health Survey, Ministry of Health

Table 11 - Body size indicators, children aged 5–14 years, by gender, Māori and non-Māori, 2013/14

Indicator (5-14 years, percent, 2013/14)	Māori			Non-Māori		
	Males	Females	Total	Males	Females	Total
Overweight	28.8	29.2	29	18.9	23.4	21.1
	(24.0–34.1)	(24.6–34.3)	(25.3–33.0)	(16.1–22.1)	(19.7–27.5)	(18.7–23.1
Obese	18.1	17.7	17.9	7.8	9.1	8.4
	(14.0–23.1)	(13.1–23.4)	(14.5–21.9)	(5.8–10.4)	(7.0–11.7)	(6.8–10.4
Mean BMI score	19.5	19.3	19.4	18.3	18.4	18.3
	(19.1–20.0)	(18.9–19.7)	(19.1–19.7)	(18.0–18.5)	(18.1–18.6)	(18.1–18.5

Notes: Figures are age-standardised to the total Māori population as recorded in the 2001 Census.

Prioritised ethnicity. Source: 2013/14 New Zealand Health Survey, Ministry of Health

Table 12 - Body size indicators, adults aged 15 and over, by gender, Māori and non-Māori, 2013/14

Indicator (15+ years, percent, 2013/14)	Māori			Non-Māori		
	Males	Females	Total	Males	Females	Total
Overweight	33.4	27.6	30.4	39.2	28.2	33.6
	(30.0–37.0)	(24.0–31.4)	(27.8–33.0)	(37.3–41.3)	(26.6–29.9)	(32.3–34.9)
Obese	42	47.2	44.7	24.7	24.7	24.7
	(38.2–45.8)	(43.8–50.6)	(42.1–47.3)	(22.8–26.6)	(23.0–26.6)	(23.6–25.9)
Mean BMI score	29.8	30.6	30.2	27.2	26.9	27.1
	(29.2–30.3)	(30.1–31.1)	(29.8–30.6)	(27.0–27.5)	(26.6–27.2)	(26.9–27.2)
Mean waist measurement (cm),	99.1	94	96.4	93.7	84.4	88.9
	(97.7–100.5)	(92.7–95.4)	(95.4–97.4)	(93.0–94.4)	(83.7–85.0)	(88.5–89.4)

Notes: Figures are age-standardised to the total Māori population as recorded in the 2001 Census.

Prioritised ethnicity. Source: 2013/14 New Zealand Health Survey, Ministry of Health

Socioeconomic deprivation

The causative connection between poverty and ill health is well documented. Measurements of deprivation and poverty are critical not only in understanding the causes of Māori health outcomes but in identifying important opportunities for intervention. The overrepresentation of Māori in the most deprived socioeconomic deciles has been diligently reported by the government with no improvement since measurement began in 199[42].

When indicators of poverty and socioeconomic deprivation are disaggregated by ethnicity and gender, Māori women experience higher levels of hardship than non-Māori males and females, and Māori men, for almost all measures (Table 13)[43].

Table 13 - Socioeconomic indicators, by gender, Māori and non Māori, 2013

Indicator	Māori			Non-Māori		
	Males	Females	Total	Males	Females	Total
School completion (Level 2 Certificate or higher), 15+ years	42.1	47.8	45.1	65.2	63.4	64.3
Unemployed, 15+ years	9.8	10.9	10.4	3.9	4.1	4
Total personal income less than $10,000, 15+ years	23	25	24.1	14.8	21.7	18.4
Receiving income support, 15+ years	23.1	36.7	30.4	10.9	16.4	13.8
Living in household without any telecommunications,[1] all age groups	3.1	2.9	3	1	0.8	0.9
Living in household with internet access, all age groups	69.4	68.6	69	84.3	83.2	83.8
Living in household without motor vehicle access, all age groups	8.1	9.3	8.7	3.7	5	4.4
Living in rented accommodation, all age groups	48.3	50.5	49.5	27.7	27.3	27.5
Household crowding,[2] all age groups	18.3	18.8	18.6	7.8	7.6	7.7

Notes: 1. Telecommunications include telephone, cell/mobile phone, facsimile and internet. 2. Based on the Canadian National Crowding Index. A required number of bedrooms is calculated for each household (based on the age, sex and number of people living in the dwelling), which is compared with the actual number of bedrooms. A household is considered crowded when there are fewer bedrooms than required.

Source: Stats NZ, presented in (43)

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Me aro koe ki te hā o Hine-ahu-one.

Pay heed to the breath of Hine-ahu-one.

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