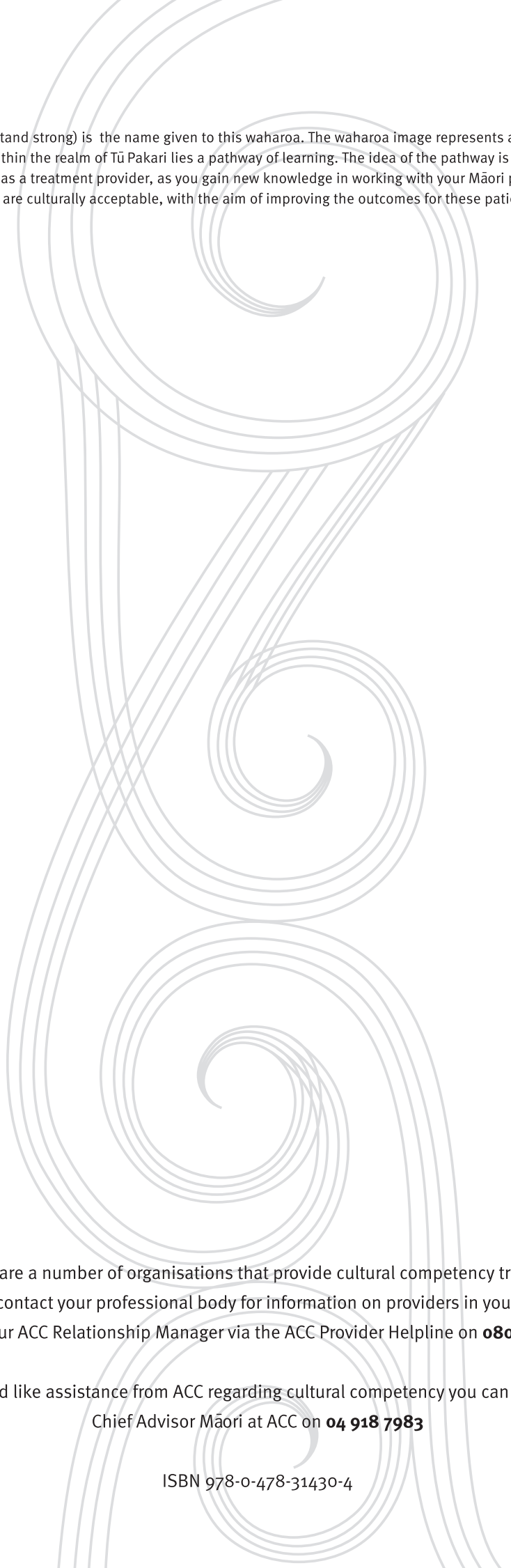


Te tūrora Māori me o mahi
The Māori patient in your practice

Guidelines on Māori Cultural Competencies for Providers





Tū Pakari (stand strong) is the name given to this waharoa. The waharoa image represents a gateway to knowledge. Within the realm of Tū Pakari lies a pathway of learning. The idea of the pathway is for ACC to walk alongside you, as a treatment provider, as you gain new knowledge in working with your Māori patients in ways that are culturally acceptable, with the aim of improving the outcomes for these patients.

There are a number of organisations that provide cultural competency training.
Please contact your professional body for information on providers in your area or
contact your ACC Relationship Manager via the ACC Provider Helpline on **0800 222 070**.

If you would like assistance from ACC regarding cultural competency you can contact the
Chief Advisor Māori at ACC on **04 918 7983**

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HE WHAKATĀUKI

The proverb on the front cover originates from the Northland tribe of Te Aupouri.

Hutia te rito
Hutia te rito o te harakeke
Kei hea te komako e ko
Kī mai kī ahau.
He aha te mea nui
He aha te mea nui o tēnei ao?
Māku e kī atu
He tangata, he tangata, he tangata

“If you remove the heart of the flax bush
From where will the bellbird sing to me?
What is the most important thing
The most important thing in this world?
I say, it is people, people, people”

To settle differences between two tribes, a marriage was arranged between the ruling families of each tribe. This resulted in peace between the tribes and eventually this arranged couple became leaders of one of the tribes.

Some years later, tensions were raised between the tribes over an incident. The arranged couple spoke of what action needed to occur to seek retribution for the incident. The husband said to his wife that he wanted to attack his wife's people to maintain his mana, as, “What was more important than that?”.

She replied with the above proverb using the analogy of the bellbird feeding from the flax bush to refer to their children's relationship with the other tribe. As they were connected to the tribe he sought to attack, they would be ostracised and have nowhere to go in times of trouble. The concluding proverb was in reply to his question that emphasised people were more important. Thus war was averted and an alternative answer was sought.

ACKNOWLEDGEMENTS

Te Kaporeihana Awhina Hunga Whara (ACC) would like to thank all those who participated in the development of these guidelines and who have given freely their knowledge and expertise. Kei te mihi kia kōutou.

Draft guidelines were developed after consultation with the Pae Arahi group (regional cultural advisors to ACC) and a systematic literature review. This draft was refined by a multi-disciplinary reference group of Māori consumers and clinicians that included physiotherapy, occupational therapy, nursing, surgical and medical representatives.

Mauri Ora Associates project team

- Dr Peter Jansen
- Dr Rees Tapsell
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Reference Group members

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Additional cultural experts

- Mr Amster Reedy
- Mr Bob Lowe
- Mr Graham Warren
- Mr Ropeti Gafa
- Professor Colin Mantell
- Mr Martin Bercic
- Mr Chad Brown

The subsequent draft was reviewed by a wider group of Māori clinical and cultural experts, and also by a hui in Auckland attended by cultural experts, ACC staff and the Mauri Ora Associates project team. Advice from these sources was incorporated into a third draft that was made available for review by individuals and organisations prior to finalisation.

Responses were received from the following:

- Dr Sue Crengle
- Dr Paparangi Reid
- Assoc Prof John Broughton
- Mr Brian Emery

- Ms Moe Milne
- Mr Owen Lloyd
- Ms Phyllis Tangitu
- Dr James Te Whare
- Dr Matire Harwood
- Ms Druis Barrett
- Mrs Kitty Bennett
- Dr Jim Vause
- Ms Te Orohi Paul
- Mr Wi Keelan
- Mr Teina Kake
- Staff and management of ACC

SUMMARY

These guidelines have been developed to assist healthcare providers in improving access and delivering appropriate advice, care and treatment to Māori clients. Information about cultural considerations for Māori and guidance on achieving compliance with the ACC Māori Cultural Competency Standards (referred to as “Hauora Competencies” throughout this document) are included, together with examples of misunderstandings that can arise if the “Hauora Competencies” are not incorporated into clinical practice.

Māori principles

During the development of these guidelines it was pointed out many times that the concepts being discussed are not just words, but reflect the essence of being Māori. Words such as mana, wairua, ea, pono, tapu and noa incorporate feelings, ways of thinking, spirituality and a Māori world view.

For example, a key concept is contained in the expression ngā wā o mua, which literally means “the times in front of me”. However, because the Māori world view sees the past as visible but the future as unknown (behind us), this phrase actually refers to times gone by. The Māori point of view is always to acknowledge the wisdom of the past and the things that connect us to the present, such as ancestors, family connections, the physical environment and spiritual matters both seen and unseen.

It is not possible to cover all issues related to cultural competence for Māori clients in these guidelines. However, by seeking a greater understanding, providers will come into contact with those who are knowledgeable in tikanga Māori – the customs of Māori. Establishing relationships with local experts will provide a point of reference for unusual circumstances. It is important to note that tikanga Māori has established processes for recovery and restoration after inadvertent breaches of custom, but these require expert assistance from knowledgeable people.

ACC MĀORI CULTURAL COMPETENCY

All contracts have an “ACC Māori Cultural Competency” schedule that includes a commitment to address the needs of Māori clients. All contracted providers must comply with the “Hauora Competencies” during the tendering and evaluation process, as well as during service delivery to Māori clients.

Meeting the requirements of the “Hauora Competencies” will assist providers in achieving goals relating to Māori health and their responsibilities for cultural competence within professional standards. The practical effect is that providers will ensure services are delivered to Māori clients in a manner that recognises and respects Māori values and beliefs.

Improving cultural competence for Māori can reduce delays in seeking care, improve the collection of clinical information, increase the understanding of Māori clients, and enhance communications between Māori clients and providers. Together these can lead to improved client/family/whānau satisfaction and greater compliance with individual care plans.

WHAT IS CULTURAL COMPETENCE?

Mason Durie¹ expresses it in this way: “*Cultural competence is about the acquisition of skills to achieve a better understanding of members of other cultures*”. He notes that the goal of culturally competent care with Māori clients is to improve relationships and thereby achieve “*better clinical results*”.

The key to understanding Māori cultural preferences is knowledge of important concepts such as tikanga, pono, noa, tapu, mana, aroha, wairua, whanaungatanga and whakapapa, together with an understanding of Māori attitudes to death and dying. In addition, providers will need to understand the variations in tikanga and cultural protocols that apply in their localities or regions, and how to apply these in a common-sense way.

In writing these guidelines and by trying to describe Māori preferences, it is possible to create or reinforce stereotypes. To avoid this, we ask providers to remember that diversity exists in every group and furthermore, like other cultures, Māori culture is dynamic. So, if a person wears a moko this may not mean that they will want to converse in te reo Māori; or someone wearing a suit and tie may not have rejected Māori cultural values. Providers need to assess each client's preferences using a number of clues, and need to learn to ask questions in a culturally sensitive fashion. Culture is an important determinant, but not the only factor that predicts health status and preferences for care. Other influences that impact on our well-being and the choices we make include environment, economics and psycho-social factors.

1. Durie M. *Cultural Competence and Medical Practice in New Zealand*. Report to the Australian and New Zealand Boards and Council Conference, November 2001

MĀORI STANDARDS OF HEALTH

Hauora: Māori Standards of Health I, which updates the *Hauora: Māori Standards of Health* series to the year 2005, notes that “In Aotearoa/New Zealand and internationally there is increasing recognition of the role that various social, economic, environmental, and political factors play in determining health experiences and outcomes for individuals and social groups (Howden-Chapman & Tobias 2000; Wilkinson & Marmot 2003). These factors include such determinants as income, employment status, housing, education, social position, and social exclusion. They can have both direct and indirect impacts on health, as well as having interrelated and cumulative effects over lifetimes”.²

Māori statistics

As at 30 June 2006, Māori comprised 14.9% of the New Zealand resident population. Statistics New Zealand population projections (series 6) through to 2026 show the Māori growth rate at 1.4% per annum, well in excess of that expected for the European/Other population (0.3% per annum).

On this basis Māori are expected to increase from 14.9% to 17% of the resident population by 2026, while European/Other will fall from 76.8% to 69% of the resident population.

While most Māori live in the North Island, every region in New Zealand has a Māori population of at least 6.7% (Otago). The largest Māori population in the North Island is the Gisborne region at 46.7% and in the South Island, Southland has the largest percentage of the Māori population at 12%. For additional information, see Appendix two.

Injury to Māori

Ethnicity data is now collected from 99% of new ACC claims, and this shows Māori entitlement claim rates are approximately 25% lower than for non-Māori. Māori also have lower average medical fees claims by approximately 15% when compared with non-Māori. By contrast, Māori continue to have higher rates of serious injury claims than non-Māori, approximately 10% higher for the 2006/07 year.

For more information on injury to Māori and Māori utilisation of ACC services, see Appendix two.

2. Robson B, Harrus R. (eds) *Hauora: Maori Standards of Health IV. A study of the years 2000-2005*. Wellington: Te Rōpū Rangahau Hauora a Eru Pomare. p21. To download, or order, a copy of *Hauora: Maori Standards of Health IV*, visit www.hauora.maori.nz

BARRIERS TO CARE

In a review of literature on barriers to care for Māori, Baxter³ cites evidence for the impact of cultural appropriateness of care, broad structural barriers and the increased impact of socio-economic barriers on Māori.

Crengle⁴ further identifies the structural barriers to care, such as:

- geographic and transport barriers, which can prevent Māori reaching a service;
- the timing and availability of services to suit Māori preferences;
- financial barriers, which are more likely to impact on Māori due to lower socio-economic status than non-Māori;
- the failure by providers to identify, treat or follow up those in greatest need;
- cultural barriers, including the acceptability of services to Māori and the provision of appropriate information to Māori.

The importance of culturally appropriate services has also been highlighted by Durie as a significant aspect of access to care:

*“The degree of comfort individuals feel with seeking health services impacts on their use of services and, in turn, health outcomes. Comfort is a product of both individual attitudes and the way in which services are delivered. The delivery of care in a culturally appropriate manner is an important element in determining both the willingness of people to access services and the success of any treatment or care then delivered.”*⁵

3. Baxter J, *Barriers to Health Care for Maori with Known Diabetes*. New Zealand National Working Group on Diabetes and Te Roopu Rangahau Hauora a Ngai Tahu, September 2002

4. Crengle S. The development of Māori primary care services. *Pacific Health Dialog* 2000, 7(1): 48-53

5. Durie M. *Mauri Ora: the Dynamics of Māori Health*. Auckland: Oxford University Press, 2001

THE IMPACT OF CULTURE ON HEALTH

E kore e taka te parapara a ōna tūpuna, tukua iho ki a ia.

The qualities of his/her ancestors will not fail to be fulfilled; they descend through him/her (there are positive influences on each of us that come from our forebears).

Culture has been described as the learned and shared patterns of information that a group uses to generate meaning among its members.⁶ These patterns include language and non-verbal communications, beliefs and spiritual associations, relationships with others, and possessions. Concepts such as “wellness” and “illness” have meanings that are contained within the language and customs of each culture. Members of a cultural group often share beliefs in certain rules, roles, behaviours and values, which shape interactions with others, such as “help seeking” behaviours.^{7, 8, 9}

- Culture influences “help seeking” behaviours and attitudes toward health and rehabilitation providers.
- Culture shapes beliefs about the causes of injury and appropriate treatments.
- Culture influences perceptions of pain and client responses to pain.
- Culture shapes the behaviours, attitudes and values of providers and their institutions.
- Clients need to overcome personal experiences of cultural bias within healthcare systems in order to achieve the best outcomes.

As both the provider and their clients bring their respective cultural backgrounds and expectations to the service encounter, there are many opportunities for confusion.

Miscommunication and Different Interpretations

The family/whānau of Mrs K are very reluctant to go to the hospital or see medical specialists because “they don’t believe what you tell them, and they treat Māori badly”. This came about after the referral of their kuia to a specialist for assessment after a fall causing injury. During talks with the family/whānau members, the specialist asked if the kuia was taking any medications. The family/whānau was clear that their kuia was not on any medicines, so they were very upset when the correspondence from the specialist stated that “the family/whānau denies the patient is on any medication”. The family/whānau took this to mean that the specialist thought their kuia was taking medicines but did not believe what the family/whānau said. In this case a common medical phrase was at odds with the language used by the family/whānau and caused unintended offence due to the misunderstanding.

(President of the Māori Women’s Welfare League)

Tip

Take care with language and medical phrases.

6. Penn NE, Kar S, Kramer J, Skinner J, Zambrana RE. Ethnic minorities, health care systems, and behavior. *Health Psychology* 1995 December, 14(7): 641-646.
7. Jansen P, Sorresen D. Culturally competent health care. *NZFamPhys* 2002 October, 27(3)
8. Cross T, Brabazon B, Dennis K, Isaacs M. *Towards a Culturally Competent System of Care*, volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center, 1989
9. Isaacs M, Benjamin M. *Towards a Culturally Competent System of Care*, volume II, programs which utilize culturally competent principles. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center, 1991

Māori clients who have experienced cultural bias are constantly striving to overcome the barriers between themselves and their providers.^{10, 11, 12} Providers for their part have a duty to achieve skilled performance¹³ in the area of cultural competence and so assist Māori to overcome these same barriers.

Principles of culturally competent care for Māori¹⁵

- Clients are best served by persons who are a part of or in tune with their culture.¹⁴
- Cultural competence requires a commitment to continuous improvement through continuing planning, education, training, review, supervision and feedback, in the same way that clinical competence does.
- In addition to the consideration given to methods for improving clinical interventions, cultural interventions require culturally competent methods by way of customer satisfaction surveys, complaints and compliments processes, existing relationships with family/whānau, iwi and hapu, and other service development initiatives.

10. Durie M. Māori attitudes to sickness, doctors and hospitals. *NZMJ* 1977, 86: 483-485

11. Tipene-Leach D. Māori – our feelings about the medical profession. *Community Forum* November 1978

12. Gribben B (for Auckland UniServices) *Integrated Care Evaluation 2000-2001 – Primary Options for Acute Care*. Counties Manukau District Health Board, December 2001

13. Competencies are those areas of skilled practice that are expected of healthcare providers

14. Laveist TA, Nuru-Jeter A. Is Doctor-Patient Race Concordance Associated with Greater Satisfaction with Care? *J Health Soc Behav* 2002 September, 43(3):296-306

15. For an explanation of terms, see Appendix three

TIKANGA – MĀORI BELIEFS

The principles and values that have guided Māori over generations collectively form what is known as tikanga or tikanga Māori. As Hirini Moko Mead notes (Tikanga Māori, Living with Māori Values, 2003), tikanga Māori is a means of social control, a normative system, an ethical system, a repository of Māori knowledge, and also a body of customary lore. Indeed, for many Māori it is hard to imagine a place or time when tikanga does not have relevance. For many Māori clients, tikanga Māori will form the basis of their interactions with health and rehabilitation providers at a time of heightened concern because of injury or death.

Kia mau ki te kupu a tōu mātua.

Adhere to the advice of your parents and ancestors.

To meet the requirements of Māori clients effectively, providers need to understand concepts such as tikanga, pono, noa, tapu, ea, mana, aroha, wairua, whanaungatanga and whakapapa,¹⁵ which form the underlying philosophy that guides tikanga Māori. While many Māori have adopted Christian beliefs, many also retain customary Māori attitudes to death, illness and injury. For example, the customs surrounding funeral rites (tangihanga) are still adhered to in most areas and by most Māori. This is hardly surprising given that Māori have been concerned with the manner in which an individual has been injured, or the manner in which death occurs, rather than seeking explanations of why injury or death has happened.

Kei mate a tarakihi koe, engari kia mate a ururoa.

Do not die like the tarakihi (which doesn't struggle when caught), but (fight to the end) like the shark.

He toa taua, mate taua; he toa piki pari, mate pare; he toa ngahi kai, ma te huhu tēnā.

A warrior dies in battle, a man who climbs on cliffs will die on the cliffs, but a gardener dies peacefully in the garden.

Customary Māori views of life, death and the afterlife are quite different from those of other cultural groups. For example, Māori expect to be able to see the face of the deceased and to talk to the deceased as though they were still alive. It should be noted that Māori beliefs and the beliefs of other cultural groups have impacted on European New Zealanders, so that it is now common for all European New Zealanders to “view the body” before burial.

Injury, illness and death all impact on the tapu of an individual and their family/whānau. Tikanga Māori is focused in a practical sense on the circumstances that caused the injury or death, so that this is not repeated and the issue can be contained, for example by avoiding places or events or by restricting activities. At the same time, illness, injury and death place obligations on relatives and friends, such as providing material, spiritual and emotional support, attending hui or representing the family/whānau in meetings with providers.

Effective care for Māori – the outcomes

By developing cultural competence, providers can improve outcomes of treatment and rehabilitation for Māori. As a result of improved communication, providers can obtain more specific and complete information that can be used to make an appropriate diagnosis and treatment plan. This will in turn lead to improved client/family/whānau satisfaction and greater compliance with treatment. Improvements in client satisfaction and communications can also reduce complaints.

PLANNING FOR IMPROVEMENTS

The “Hauora Competencies” require providers to meet the needs of Māori clients effectively. To achieve these, providers should develop policies (or statements of best practice) that cover the following areas:

- How the provider will consult iwi/Māori;
- Training for all staff in ACC Māori Cultural Competency and Māori preferences;
- Effective collection of ethnicity data and the appropriate use of that data;
- Workforce development for Māori staff;
- Culturally responsive and appropriate service delivery;
- Identification and reduction of inequalities between Māori and other New Zealanders.

Assistance with these policies can be found by referring to iwi/Māori communities and in resources available from the Ministry of Health, District Health Boards and the regional cultural advisors (Pae Arahi) of ACC.

For example, the Ministry of Health website (<http://www.moh.govt.nz>) contains guidelines on consultation with Māori, listings of Māori health and disability providers, and strategies that contribute to Māori health gain.

A key component of improving care for Māori is the comparison of access to treatment and outcomes between Māori and non-Māori. If inequities in access or outcomes for Māori compared with need (or compared with non-Māori) are found, providers can develop plans to address these. Comparisons can only be made if accurate ethnicity data is collected by each service provider.

Involving the Māori community

To be effective, providers need to understand the community they serve by establishing relationships with iwi, Māori providers, Māori health professionals and Māori in their localities. An effective way to do this is by attending hui and forums, and sporting and community events, in addition to direct contact with local marae. Developing relationships with Māori will assist in understanding Māori values and beliefs, and should lead to increasing participation by Māori as required in the “Hauora Competencies”.

Effective Māori participation will extend across all aspects of care, from planning and delivery of care to evaluations and reviews. This process may require support for Māori groups and individuals who are consulted, and advice to providers.

Ki nga whakaeke haumi.

Join those who have already banded together.

Training and planning

Providers should develop a training plan for all staff that covers the following areas;

- Tikanga Māori, Māori world views, Māori preferences for care;
- Barriers to effective care;
- Communication skills with Māori clients;
- Māori health frameworks and models of health and rehabilitation;

- Ethnicity data collection;
- Links with Māori providers and iwi/Māori communities;
- ACC Māori Cultural Competency.

Providers may need to engage qualified trainers, institutions or wananga with experience in developing training programmes for Māori cultural competence. The training programme should include regular updates for all staff, and may need to be repeated for new staff members. Staff with health or specialist qualifications and expertise may require more specific or expert training and all staff should be encouraged to attend local hui and forums. The outcome of a training plan will be a comprehensive plan within each workplace that can achieve improvements in access, care and rehabilitation for Māori.

Workforce development

Providers should develop a workforce plan so that over time the staff composition will reflect the community they serve, and also that Māori staff will have opportunities for development. This will include support for clinical training and other opportunities for skill development of existing Māori staff, and may include sponsored training to encourage Māori employment.

Collection of ethnicity data

Cultural competence is built upon the accurate and consistent collection of ethnicity data and this must be consistent with ACC requirements and other regulations. This data can be used to plan improvements to services for Māori by comparing access to services and outcomes of care for Māori and non-Māori. Without this information services cannot measure their effectiveness and any existing disparities will likely continue.¹⁶

Te Rōpū Rangahau Hauora a Eru Pomare at the Wellington School of Medicine has extensive experience in improving ethnicity collection by providers, and in interpreting service use by ethnicity. It makes the following observations regarding data collection.

In a seminar on Māori health, a general practitioner reported difficulties in collecting ethnicity data. The GP had resorted to apologising to patients for asking the question then adding that the information was required for government statistical purposes. Other GPs in the area had had greater success in collecting ethnicity data and told of their experiences. Key points included:

- a policy of collecting ethnicity data and other demographic information on all patients, so that each patient and their family/whānau could be assured of receiving care appropriate to their needs;
- the need for the whole practice team to adopt a consistent approach;
- providing training and feedback on ethnicity data collection to the practice team.

(Māori GP)

Tips for ethnicity data collection

- Ask the ethnicity question – do not guess or make an assumption based on skin colour or facial features.
- Provide an explanation of why, how and when the information will be used and that the information is confidential.
- Note that clients may choose not to answer, or may wish to select multiple ethnicities.
- it is very important that the person asking the question does so in an appropriate way and the client is given enough time to answer.
- If in doubt, seek help with training for all staff.

16. Reid P, Robson B, Jones CP. Disparities in health: common myths and uncommon truths. *Pacific Health Dialog* 2000, 7 (1):38-47

COMMUNICATIONS – A KEY ISSUE

Studies from around the world confirm that patients/clients place the greatest emphasis on the communication skills of providers. Client satisfaction with care and the acceptability of treatment^{6, 17, 18} are associated with the ability of providers to show they understand their clients and are understood by their clients.⁸

He tao rakau, e taea te karo; he tao ki, e kore e taea te karo.

A wooden spear shaft can be parried, but a verbal spear cannot be parried.

(This proverb is the opposite of the Western proverb – “Sticks and stones will break my bones but names will never hurt me”).

Māori clients also value highly the communication skills of providers.^{19, 20} The whakatāuki (proverb) above reflects Māori feelings about the importance of the spoken word. Mispronunciation of Māori names and words is jarring to Māori ears, as it implies a lack of respect for Māori.

Tip

When unsure about pronunciation of Māori names, ask the Māori client or the family/whānau for help, rather than risk giving offence.

Few Māori clients have access to culturally concordant providers,^{9, 17} as the majority of healthcare providers in New Zealand are non-Māori. The lack of cultural concordance is reflected in access to care,²¹ adherence to treatment²² and outcomes for Māori clients. Developing the cultural competencies of providers can improve this situation.

For example, Māori are less likely than non-Māori and non-Pacific peoples to question treatment plans, so clinicians need to check on the understanding of Māori clients in different ways. This can be through indirect questioning and the use of family/whānau members, or by using Māori health workers and kaumātua when necessary.^{7, 10}

Best Practice is Built on Effective Relationships

Mr H, a kaumātua with shoulder pain, was referred for an arthrogram. He was initially very wary, but a Māori student physiotherapist introduced herself and was able to establish a rapport. As it happened they both had connections to the same marae, and spent a few minutes talking about family/whānau and related matters. After that the student was able to explain the X-ray procedure in a way that was meaningful for Mr H. In addition, the student arranged for family/whānau members to make contact with Māori liaison staff from the hospital to ensure that his further appointments went smoothly.

(Māori physiotherapist)

17. Fortin AH. Communication skills to improve patient satisfaction and quality of care. *Acad Med*. 2000 November, 75(11):1071-1080

18. *A Survey of Determinants of Patient Satisfaction with GPs in Auckland*. The Radford Group report to ProCare Health Ltd, 1996

19. Jansen P. Improving consultations with Māori clients. *NZ FamPhys* 1998 April, 25(2)

20. Cram F, Smith L, Johnstone W. Mapping themes of Māori talk about health. *NZMJ* 2003 March, 116 (1170) <http://www.nzma.org.nz/info/journal/116-1170/357/>

21. Arroll B, Goodyear-Smith F, Lloyd T. Depression in patients in an Auckland general practice. *NZMJ* 2002 (1152): 115

22. *Prescription Presentation Rates in South Auckland*. Unpublished study by ProCare IPA, Healthcare Management Associates and the Northern Regional Health Authority, 1996

In general Māori prefer personal contacts, with the aim of seeing the face, hearing the voice and observing the body language or behaviour of people who are unknown. This approach is integral to establishing proper relationships and if not followed may result in Māori clients not engaging with providers.

Te kanoahi kitea o Taihako.

The shining face of Taihako.

(Māori prefer to make requests and discuss plans in person or face to face.)

Kanoahi Kitea: A Face Seen

Mr TN, a paraplegic for 15 years following a motor vehicle crash, lived near his ancestral marae, which was 20 kilometres from the nearest town. When telephoning to arrange appointments or seek information, many of the team involved with his care found him to be surly and uncooperative. The case manager sought assistance from Māori staff in ACC and they quickly determined that many of the team currently involved had never met Mr TN. A meeting was arranged that included ACC staff, Māori clinicians and Mr TN's family/whānau. After a formal welcome and refreshments provided by the family/whānau, all team members were introduced and Mr TN was able to demonstrate the difficulties he experienced in daily life. He was then able to express his concern that few of the team caring for him had visited him to see how he was coping with everyday tasks. Following that, a productive meeting was held, leading to a plan for further care and rehabilitation that included regular face-to-face meetings and introductions of new team members.

(ACC)

Tip

By following Māori processes, providers and case managers can achieve better outcomes for Māori clients.

GENERAL GUIDANCE ON SUPPORTING MĀORI PREFERENCES

The following sections provide general advice only. For specific issues, please refer to the readings listed at the end of these guidelines.

Initial contacts

When first attending a provider, Māori may appear reticent and nervous. The appropriate use of space and time is important at first contact to give time for the Māori client and the provider to get to know each other. Remember that the Māori client is visiting your facility, and may expect or prefer certain rules or processes to be followed. For example, the provider should lead the way into each room, indicate where to sit, introduce themselves, and allow time for the client to make their own introduction. For many Māori, this first encounter takes as a reference the powhiri – where the encounter should follow time-honoured processes that include sufficient time and space to allow each party to understand the other through introductions, establishing connections, and removal of restrictions (tapu). Rushing the first meeting, or not allowing sufficient time for face-to-face interaction can have a negative impact on relationships and hence on adherence to treatment plans.

Family/whānau support

Māori often bring family/whānau to support them and this should be encouraged as a way to improve communication. The family/whānau may nominate one person to speak on behalf of the client and family/whānau. This must be respected and acknowledged by allowing time for that person to consult the rest of the family/whānau before decisions are made. Flexibility should also be given to visiting times and visitor numbers. Family/whānau may also request to be present during a procedure, consultation or overnight admissions. Where this cannot be permitted, give an explanation to the client and family/whānau.

Hongi

This is the touching of the noses and mingling of breath, followed by a hand shake, when introductions are complete. Be guided by Māori clients as to whether a hongi is appropriate.

The head

To signal informal greetings or check for affirmation, many Polynesian cultures, including Māori, may use a slight movement of the head and raise the eyebrows.

Touching another person's head is considered offensive by many Māori. It is therefore inappropriate to touch another's head without permission.

Eye contact

For Māori, making direct eye contact can be a sign of disrespect, especially when directed towards authority figures. It is acceptable to avoid prolonged eye contact as a sign of respect and deference. More importantly, you need not feel uncomfortable if a Māori client does not sustain eye contact and prefers to look at a neutral point in the room. Māori often say that we “listen with our ears, not our eyes”.

Tips

- Be guided by the client or the family/whānau, and let them set the scene for that first meeting. Take time to introduce yourself, and if they wish to hongi, you may do the same.
- Use gestures with great caution. Gestures can mean very different things in different cultures.
- Be careful in interpreting facial expressions. They may lead you to misinterpret the client's feelings or level of pain, as these are closely tied to a person's culture.
- Don't force a Māori client to make eye contact with you. They may be treating you with greater respect by not making eye contact. At the same time, observe Māori clients for non-verbal communications such as a shrug of the shoulders.
- When visiting Māori at home or on a marae, leave sufficient time for refreshments – these may be offered once introductions are complete and signify the removal of tapu. If you are not sure of the correct process, it is best to ask rather than risk offence.

Karakia (blessings/prayer)

Māori clients or their family/whānau may want to say karakia before any or all procedures and particularly at times of heightened concern, for example surgery and the administration of blood products. Some clients or family/whānau may wish to retain body fluids or tissue or perform karakia before the disposal of these. It is important to allow discussion of these matters before elective procedures occur and provide explanations to clients or family/whānau if retention of tissue or fluids is not possible. More examples are provided in the Tikanga Recommended Best Practice Policy produced by Auckland District Health Board.

Different Understanding of Behaviour?

Mrs A had been admitted to hospital for treatment of a serious condition, but after a week asked if she could return home. Hospital staff observed Mrs A singing waiata, and concluded that the patient was indeed feeling better so began arrangements to have the patient discharged. Meanwhile the family/whānau of Mrs A were making arrangements for their kuia to go home to die, because they hadn't heard her sing those old waiata before.

(Cultural Advisor to ACC)

Tip

Check with the client and their family/whānau before making assumptions about the reasons why Māori clients act in particular ways.

First meeting

All staff should introduce themselves and explain their role to the client and family/whānau. It is very important to pronounce Māori names correctly or ask when unsure. For many Māori, names are connections to the past and the present, so getting this right is a mark of respect.

Seek Help with Pronunciation

Mr Ngawharau took his daughter, Pounamu, to a busy accident and medical clinic and was asked to fill out various forms and take a seat in the waiting room. The clinic triage nurse explained that she found it hard to pronounce their name and suggested that she would call the injured child Jade, as that was much easier for her. Jade is the English equivalent of pounamu (or greenstone). The father and daughter left without receiving further care, but presented later to a hospital emergency department.

(Māori nurse)

Tip

Ask the family/whānau on how to pronounce names correctly as a show of respect.

Collecting or imparting information

As each person has different preferences for receiving information, providers need to consider offering information in a number of ways to ensure that adequate understanding is achieved. For most Māori, the preferred method of exchanging information is face to face (kanohi ki te kanohi). If this is not possible, a telephone call is likely to be valued ahead of written communications.

For many Māori, an individual's health problems are also considered the problems of the family/whānau, and it can be considered threatening to exclude family/whānau members from any medical interaction. For these clients, providers can address the individual's health problem in the context of their family/whānau after seeking consent from the individual client. Family/whānau members can provide valuable information regarding the client's diet, health behaviour, daily activities and types of alternative medication used. Their involvement in a treatment plan may be vital to a client's ability to adhere to the recommended treatment.

At the same time, it is not always culturally appropriate to involve family/whānau members, and the provider must be sensitive about when it may NOT be appropriate, such as in issues relating to genital examination.

In many cases the family/whānau will have designated a single person to lead interactions with the provider.

Mr HH (15 years) was undergoing MRI to assess his injury. Family/whānau members had travelled some 90 kilometres with him to the appointment but were told after the scan was complete that the results would be made available only through the referring doctor. The family/whānau was upset because some had taken time off work, expecting a discussion of the findings with the radiologist. They had not been told about the policies and reporting processes of the MRI unit.

(Māori occupational therapist)

Tip

It is advisable to ask the family/whānau about their preferences for communication, and indicate that information can be provided via a nominated individual. Check that clients have understood any treatment, investigation or rehabilitation plans.

Support for clients

Inform clients and family/whānau of the availability of assistance from designated Māori staff within your organisation, where possible. If no designated Māori staff are available, it is advisable to maintain an up-to-date list of contacts to assist clients and family/whānau who enter your service.

Ask Māori clients and family/whānau if they have any special cultural, spiritual, language or other needs, and document these. Provide verbal and written information and support regarding complaints procedures.

Informed consent

Māori need as much information as other people, and may require family/whānau involvement before making a decision to consent. If the client is unconscious or unable to consent, look to family/whānau for guidance, and give an explanation before continuing.

Tip

Do not take silence as assent. Always check client understanding and concerns with open questions. For example, you could ask, “I want to be sure that I have given you all the information you need. Can you tell me what you understand will happen to you, from what I have said?”.

Food

Food should never be passed over the head. Fridges/freezers used to store food or medication for human consumption should be clearly identified and not used for any other purpose. Tea towels should be used only for the purpose of drying dishes, and washed separately from all other soiled linen. Anything that comes into contact with the body or body fluids must be kept separate from food, e.g. combs or brushes should not be placed on surfaces where food is placed, and receptacles used for drinking water should be used solely for that purpose. Staff should not sit on tables or workbenches and particularly on surfaces used for food or medication.

Tip

Receptacles for excreta, lab samples and food must always be kept separate.

All of these basic Māori practices rely on understanding tapu and noa, and are entirely consistent with a logical Māori view of hygiene.

Linen

Different coloured pillowcases can be used to differentiate pillows for the head and those used for other parts of the body (e.g. blue for the head and white for other parts of the body). Pillowcases should not be used for other purposes; and where possible use different coloured flannels to differentiate which flannels are used for the head and which for the body. Providers will need to ensure that preferences for care are acknowledged and met wherever possible.

Pending death

Rituals surrounding death and dying are amongst the most important for most Māori.

The tangihanga (mourning and funeral rites) places obligations on friends, family/whānau and hapū, such as hosting those who come to pay respects, caring for the immediate family/whānau (kirimate) during the days of mourning and making all necessary arrangements for the burial. Māori will travel vast distances to attend tangihanga because of the importance of these rituals, linking as they do to principles such as whakapapa, mana, wairua, tapu and whanaungatanga.

The main reasons for attending are to:

- support their family/whānau;
- maintain links;
- express emotions;
- “look upon the face” of the deceased;
- assist the family/whānau to restore the balance of life to normal (ea).

As death approaches, the personal tapu of an individual escalates, especially where blood has been shed from injury. This affects the surroundings of both the person and their family/whānau, who will often seek assistance from tohunga or ministers of religion in protecting the whole family/

whānau during this time of great concern. If death is imminent, providers should give family/whānau the choice of taking their family/whānau member home. Otherwise a single, private room should be made available for the family/whānau.

Providers can reduce anxiety and assist clients and their family/whānau by being available to discuss concerns, and by assisting in arrangements before and after death.

Following death

Providers should be guided by the family/whānau on the cultural and spiritual practices that need to be followed. A single, private room must be made available for the tūpāpaku (body of the deceased) and the grieving family/whānau. Food or drink **MUST NOT** be taken into this room. The family/whānau may wish to wash and dress the tūpāpaku. Family/whānau must be consulted and consent obtained before a post-mortem takes place.

Tip:

Ask family/whānau members to explain any procedures of which you need to be aware before you attend to the tūpāpaku.

Pain

Pain is one of the commonest symptoms encountered by treatment and rehabilitation providers. Pain may also be associated with diagnosis (injections, acupuncture), treatment (operations) and rehabilitation (physical therapies).

However, people respond differently to pain because of social, cultural and psychological factors. Māori, like many other cultural groups, bear wounds from sports or “battle” stoically, as these are the lot of a warrior. This is similar to the typical New Zealand understatement when ill. “I’m feeling a bit crook, doc” can indicate anything from a minor illness to a life-threatening constellation of symptoms.

Studies of pain behaviours across cultures emphasise the need to be wary of cultural or ethnic stereotypes.²³ While there are cultural differences, it is always important to assess each person individually.

Waking from a surgical procedure, a Māori client, Mr P, was agitated but the recovery room staff were unable to find out what the problem was because he was speaking in te reo Māori. A medical student known to the client was able to explain that the client was very cold and was asking for a blanket. The surgical unit forbade family/whānau members from the recovery room.

(Māori surgeon)

Tip

Communications with Māori clients can be enhanced in times of stress by the inclusion of family/whānau members.

23. Kleiman A, Brodwin P, Good B, Good M. Pain As human experience: an introduction. In Good M, Brodwin P, Good B, Kleiman A. (eds). *Pain As Human Experience: an anthropological perspective*. University of California Press 1992:77-99

FURTHER INFORMATION

Acknowledgements

ACC funded the development of these guidelines by Mauri Ora Associates. We thank the many individuals and organisations that contributed to this work.

Links/websites

ACC	http://www.acc.co.nz
Ministry of Health	http://www.moh.govt.nz
MOH Māori Health website	http://www.maorihealth.govt.nz
Māori Health Workforce Development	http://www.hauora.com
Land Transport New Zealand	http://www.ltsa.govt.nz
The Māori Medical Practitioners Association; Te Ohu Rata o Aotearoa (Te ORA)	http://www.teora.maori.nz
National Council of Māori Nurses	http://www.ngangaru.co.nz/ncmn
Māori Mental Health	www.maraehealth.co.nz www.matatini.co.nz
Statistics New Zealand	http://www.stats.govt.nz
New Zealand Health Information	http://www.nzhis.govt.nz
Te Puni Kōkiri	http://www.tpk.govt.nz
National Health Committee	http://www.nhc.govt.nz
Te Aka Kumara O Aotearoa; A directory of Māori organisations	http://www.takoa.co.nz

Further reading

- Tikanga Recommended Best Practice. Auckland District Health Board, March 2003
- Mead, Hirini Moko. *Tikanga Māori, Living by Māori Values*. Huia Publishers, 2003
- Tikanga Guidelines. Waikato District Health Board

APPENDIX ONE

ACC MĀORI CULTURAL COMPETENCY

The following section contains the current “Hauora Competencies” clause included in ACC contracts. The clause and competencies are subject to regular review to ensure they remain relevant.

ACC’s focus:

- a. It is imperative for ACC to be responsive to the needs of Māori. ACC recognises its clear obligations under the Treaty of Waitangi to enhance and improve the design of, access to, delivery and monitoring of policies and programmes which impact on the economic opportunities and social outcomes for Māori
- b. All Services under this Agreement will recognise the needs of Māori Claimants to have Services provided in a way that recognises their social, economic, political, cultural and spiritual values.

The Services provided by the Provider will therefore seek the best means to practise:

- a. Tikanga mo ngā iwi me ngā hapu
- b. Tino Rangatiratanga
- c. Whanaungatanga
- d. Te taha tinana
- e. Te taha wairua
- f. Te taha whānau
- g. Te taha hinengaro

Services provided by the Provider will take into account the three articles of the Treaty of Waitangi and their practical application.

- (a) Implications of article one: Kawanatanga – Governorship and the Crown’s obligation to be responsive to Māori.
 - i. The Provider will ensure its Services meet the needs of Māori Claimants
- (b) Implications of article two. Tino rangatiratanga – control and authority given to Māori to meet the specific needs of Māori where appropriate and relevant.
 - i. The Provider will involve Māori claimants and their whānau in the planning, delivery and supervision of rehabilitation services.
- (c) Implication of article three. Oritetanga – Outcomes for Māori to achieve completed rehabilitation at the same level as all other New Zealanders.
 - i. The Provider will ensure that the Services contribute to achieving equal outcomes for Māori Clients as for all other Clients.

APPENDIX TWO

INFORMATION ON MĀORI AND INJURY TO MĀORI

The Māori population

Table 1 below presents Statistics New Zealand Census 2006 data on ethnicity by region, and illustrates the geographic distribution of Māori peoples throughout New Zealand.

As at 30 June 2006, Māori comprised 14.9% of the New Zealand resident population. Statistics New Zealand population projections (series 6) through to 2026 show the Māori growth rate at 1.4% per annum, well in excess of that expected for the European/Other population (0.3% per annum).

On this basis Māori are expected to increase from 14.9% to 17% of the resident population by 2026 while European/Other will fall from 76.8% to 69% of the resident population.

Table 1:
Percentage of ethnic groups by region.

<i>As at 30 June 2006</i>	<i>Māori</i>	<i>European/Other</i>	<i>Pacific</i>	<i>Asian</i>
Total NZ	14.9%	76.8%	7.2%	9.7%
Total North Island Regions	17.1%	72.3%	8.9%	11.3%
Total South Island Regions	8.0%	91.1%	1.9%	4.6%
Northland Region	31.4%	77.4%	2.8%	2.0%
Auckland Region	11.4%	62.5%	14.8%	19.6%
Waikato Region	21.3%	80.3%	3.4%	5.2%
Bay of Plenty Region	27.7%	77.8%	2.8%	3.4%
Gisborne Region	46.7%	62.4%	3.3%	2.0%
Hawke's Bay Region	23.9%	79.4%	4.0%	2.6%
Taranaki Region	16.1%	89.0%	1.4%	2.3%
Manawatu-Wanganui Region	20.0%	83.7%	2.8%	4.0%
Wellington Region	13.1%	78.9%	8.3%	8.7%
Tasman Region	7.2%	95.9%	0.8%	1.4%
Nelson Region	8.9%	92.8%	1.8%	2.7%
Marlborough Region	10.6%	92.9%	1.6%	1.7%
West Coast Region	9.8%	94.7%	1.1%	1.3%
Canterbury Region	7.4%	89.5%	2.2%	6.1%
Otago Region	6.7%	92.1%	1.7%	4.4%
Southland Region	12.0%	92.8%	1.7%	1.4%

Source: Statistics New Zealand Census 2006 Table Builder.
Rows do not total 100% due to recording of multiple ethnicities.

Injury to Māori

The following graph and tables are sourced from information provided to ACC from clients. ACC collects ethnicity data from 99% of new entitlements. Analysis of this data shows that:

- Māori represent 14.9% of the resident population, but account for less than 12% of entitlement claims;
- Overall, Māori have lower claim rates than non-Māori (all other ethnic groups combined). Māori entitlement claim rates are approximately 25% lower than for non-Māori (see Table 2);
- While the lower entitlement claim rates are apparent for both Māori earners and non-earners, the disparity is far greater for non-earners where the Māori rate is nearly 60% lower than that for non-Māori (c.f. 15% disparity for earners) (see Tables 3 and 4);
- Māori continue to have higher rates of serious injury claims than non-Māori, approximately 10% higher for the 2006/07 year (see Table 5);
- Māori are more than 50% less likely to claim ACC compensation following a treatment injury than non-Māori (see Table 6);
- The average cost of med fee only claims is consistently lower for Māori than for non-Māori by approximately 15% (see Table 7).

Graph 1:

New entitlement claim rates per 100,000 population by gender and age group 2006/07

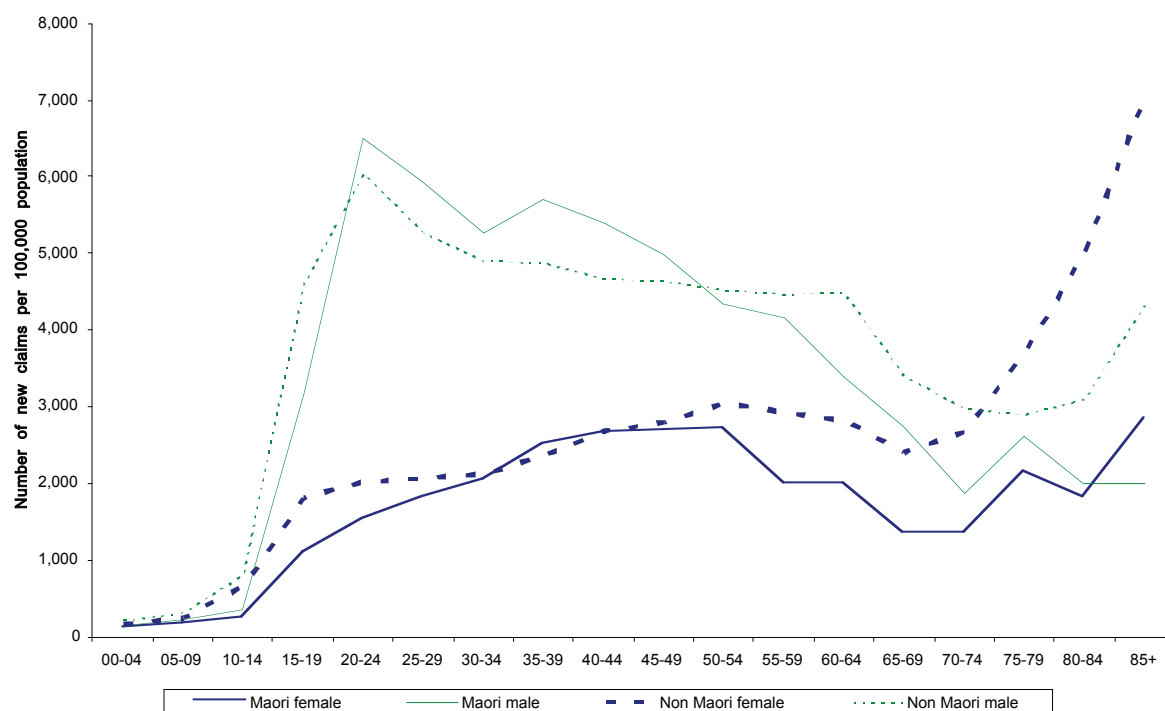


Table 2:
Rate of new entitlement claims per 100,000, Māori versus non-Māori (all funds)

<i>Financial Year</i>	<i>Māori Rate per 100,000</i>	<i>Non-Māori Rate per 100,000</i>
2001/02	1,929.7	2,557.9
2002/03	2,067.5	2,691.1
2003/04	2,086.1	2,815.7
2004/05	2,147.9	2,866.7
2005/06	2,139.6	2,843.5
2006/07	2,266.4	3,024.5

Table 3:
Rate of new entitlement claims per 100,000, Māori versus non-Māori – earners only

<i>Financial Year</i>	<i>Māori Rate per 100,000</i>	<i>Non-Māori Rate per 100,000</i>
2001/02	1,555.7	1,850.6
2002/03	1,702.6	1,972.5
2003/04	1,749.2	2,065.8
2004/05	1,777.7	2,094.8
2005/06	1,764.2	2,107.0
2006/07	1,855.7	2,203.0

NOTE: earners is defined as claims paid from employers, self-employed, earners and residual funds

Table 4:
Rate of new entitlement claims per 100,000, Māori versus non-Māori – non earners only

<i>Financial Year</i>	<i>Māori Rate per 100,000</i>	<i>Non Māori Rate per 100,000</i>
2001/02	265.7	586.0
2002/03	255.2	595.6
2003/04	249.8	615.9
2004/05	243.2	631.3
2005/06	233.7	583.9
2006/07	273.7	651.6

NOTE: non-earners is defined as claims paid from the non-earners fund.

Table 5:
Rate of new serious injury claims per 100,000, Māori versus non-Māori

<i>Financial Year</i>	<i>Māori Rate per 100,000</i>	<i>Non-Māori Rate per 100,000</i>
2001/02	10.4	6.0
2002/03	7.9	4.7
2003/04	6.1	4.4
2004/05	7.5	4.7
2005/06	6.9	5.4
2006/07	7.7	6.9

Table 6:
Rate of new treatment injury claims per 100,000, Māori versus non-Māori

<i>Financial Year</i>	<i>Māori Rate per 100,000</i>	<i>Non-Māori Rate per 100,000</i>
2001/02	4.3	10.5
2002/03	4.4	10.1
2003/04	3.5	10.0
2004/05	5.4	14.0
2005/06	8.4	19.4
2006/07	13.1	29.3

Table 7:
Average cost of med fee claims, Māori versus non-Māori

<i>Financial Year</i>	<i>Māori</i>	<i>Non-Māori</i>
2001/02	\$146.70	\$168.62
2002/03	\$155.53	\$180.32
2003/04	\$157.96	\$186.50
2004/05	\$185.54	\$217.94
2005/06	\$207.51	\$243.79
2006/07	\$217.53	\$255.52

Definitions:

Entitlement claim (moderate to serious):

An entitlement claim is a claim that does not consist of only medical fees but has also received additional support such as weekly compensation or rehabilitation at some point in its case history. These types of payment are called entitlement payments.

New claims: A claim is new in the year the first payment is made.

Earners: Earner claims are defined as claims paid from employers, self-employed, earners and residual funds.

Non-earners: Non-earner claims are defined as claims paid from the non-earners fund.

Treatment injury: A treatment injury is an injury that occurs when a person is seeking or receiving treatment from one or more registered health professionals. By “treatment” we mean diagnosis, monitoring, investigation, advice and actual treatment received.

Med fee only: These are claims where ACC has paid a health professional for medical treatment or service. A high percentage of all claims are in this category and these claims often involve only a few visits to one or a few health professionals. The client generally has no direct dealings with ACC. A claim is deemed to be a medical fee only/treatment only claim if ACC is only purchasing medical, dental treatment or counselling. These claims are sometimes referred to as minor claims.

Serious injury: If a person has an injury that results in a significant impairment or loss of function (often permanent), ACC classifies that person’s claim as a serious injury claim. Injuries must meet a set of clinical criteria to be classified as “serious injury”, but in general consist of the following types of injury:

- Moderate to severe traumatic brain injury.
- Spinal cord injury.
- Other catastrophic injury (e.g. multiple amputations, burns to over 50% of the body).

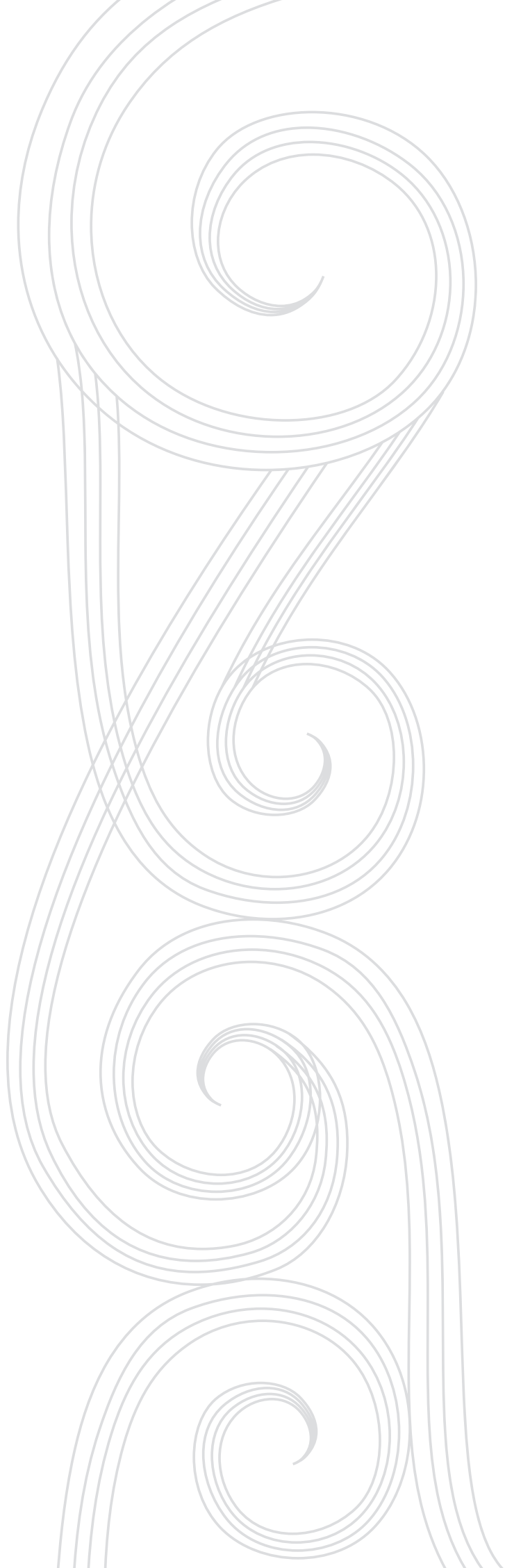
APPENDIX THREE

GLOSSARY OF IMPORTANT TERMS

Aroha	The principle by which we express love, empathy, compassion, joyful relationships and respect to each other.
Ea	Satisfaction, through the completion of tasks or rituals.
Hapū	Sub-tribe, clan.
Hara	Any wrongdoing is hara, and can impact on the wairua of a person. The assistance of tohunga and confession assist healing, otherwise the effects of hara can last a lifetime.
Hauora	The well-being of people.
Hongi	Touching of noses/foreheads, and mingling of breath when greeting others.
Hui	A meeting.
Iwi	Tribe, bone, race, people, nation.
Kanohi ki te kanohi	A face to face meeting.
Karakia	Prayer, incantations.
Kaumātua	An elder (generally male, but some apply the term kaumātua to both men and women).
Kirimate	Reference to the immediate family of the deceased.
Kuia	An elder (female).
Koha	A donation, freely given without expectation of any return.
Mana	Mana belongs to an individual and to the tribe. Mana is acquired through lineage, but more importantly through recognition of performance and service to others, wisdom and humility.
Manuhiri	The visitors or guests.
Māuiui	Malaise (someone who is not feeling well).
Mauri	The life force that exists in all things, both alive and inanimate.
Moko	A facial tattoo that is based in whakapapa (genealogical references).
“Ngā wā o mua”	Literally means “the times in front of me”. However, because the Māori world view sees the past as visible but the future as unknown (behind us) this phrase actually refers to times gone by.
Noa	All things have a balance of tapu and noa. Noa is the part that manages the relationships to other things free from restriction. It also refers to a state of balance, the common or profane. For example, eating and drinking together after the initial welcome of strangers (an act of noa) has the effect of restoring the balance of tapu and noa, after which the parties can set about other tasks.
Pono	A principle that calls for integrity and truth in one’s actions.
Powhiri	Traditional Māori welcome which takes place usually when going on to a marae.
Tangata	One person, an individual.
Tāngata	People – generic term that recognises all classes of people.
Tangata whaiora	Term adopted by mental health consumers to describe themselves.
Tangihanga	Mourning and funeral rites. For Māori these are the most important of all rituals and include sharing of grief, takahi kainga (literally the trampling of the home), kawē mate (taking the memory around), and hura kohatu (unveiling funerary

	stones). The mourning processes often take a year to complete. During the initial days of mourning, friends and relatives gather for the tangi, and make a point of getting there on time to “look upon the face” of the tūpāpaku (the body of the deceased), and to express emotions openly and unashamedly.
Tapu	The all-pervading force that comes from atua (gods) as identified in the Māori creation myths. All things have a balance of tapu and noa. Tapu in the “restricted” sense was used to prescribe human behaviour, for example in times of illness, childbirth and menstruation, and in relation to activities such as eating. Personal tapu is also related to the sanctity or sacredness of a person and of places. As tapu is concentrated on the head, objects coming into contact with the head are highly tapu. Just as food should never make contact with the head, hats, hairbrushes, combs and scarves must never be placed on tables where food may be placed, nor should a person sit on a table or a pillow.
Te reo Māori	The Māori language, to speak Māori.
Tika	A principle to do what is right and proper.
Tikanga	Customs.
Tohunga	Is a generic term for an expert; an expert recognised by the people. Today, tohunga can assist in dealing with sickness that has a mental or social component. Tohunga are available through kaumātua and Māori clergy.
Tūpāpaku	The body of a deceased person.
Tūroro	A person who is sick.
Waiata	A chant that accompanies a speech.
Wairua	The spiritual force within people.
Whakapapa	Genealogy, the origins of people and their connection with others.
Whakatau	To restore balance through acknowledgement. All things have equal amounts of noa and tapu. When someone is sick or injured, that balance is affected with the environment. The use of karakia to whakatau is one method of restoring that balance.
Whānau	Immediate and extended family.
Whanaungatanga	Establishing family/whānau connections to maintain the warmth and cohesion of a group.

NOTES





How to contact **ACC**

please contact your nearest branch,
or call ACC on **0800 101 996**