People and Health

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Maoris take up the fight against ill health

The beginnings of grass-roots primary care are taking shape in New Zealand’s Maori community. By referring to a scheme initiated in the Waikato area, the authors explain the difficulties encountered by this ethnic minority in striving towards self-help in matters of health.

In the past there were bitter clashes in New Zealand between the Polynesian Maoris and the more recently arrived Europeans, and today tensions still exist between the two groups. Diseases such as smallpox and polio, introduced by the Europeans, had catastrophic effects on the formerly isolated Maoris. In the Victorian era, the Maoris did not have access to hospital treatment and standard medical services. Indeed, by the late nineteenth century the Maoris were approaching extinction.

Official racial barriers have been removed but more subtle obstacles remain, leading to disproportionately high levels of morbidity and mortality among Maoris. Economic restraints associated with inferior employment opportunities limit access to doctors on a fee-for-service basis. Cultural conflicts linked with insensitivity among Europeans to Maori tradition and concerns are pervasive. Ignorance or disparagement of Maori beliefs and practices among medical personnel frequently underlies a lack of compliance with or avoidance of medical services by Maoris.

A health scheme for Maoris

During 1981-83 a pilot health study was made of more than 500 residents of the Waikato area (1). The majority of the participants were Maori and affiliated to at least one marae or traditional Maori ceremonial centre. The study focused on blood pressure and related anthropometric measurements and also covered diet, health concerns and interactions with existing medical facilities. The findings paralleled those of other studies in Maori populations (2-4). There were higher levels of essential hypertension, morbidity and mortality among Maoris than among Europeans. In contrast with former studies, a major conclusion was that there was a distinct level of dissatisfaction with existing...
medical services. Most vigorously expressed was a desire for greater recognition of Maori beliefs and concerns by the medical fraternity.

The introduction of a marae-based health-orientated programme was recommended. Numerous meetings followed with people in the Maori community and members of the district health department. The proposal coincided with a period of Maori political and social revitalization, accompanied by a growing recognition in the New Zealand medical community of the disparity between Maori and European morbidity and mortality rates. Within a year, a Maori health centre was established in Waahi, where the original study had been made. Coincidentally, Maori health was officially designated a nationwide top priority by the National Department of Health.

After months of discussion and in cooperation with the national and district health authorities, the marae committee in Waahi selected three women, who were long-term residents and mothers of large families, to serve as primary health care staff. The committee considered that choosing a name for this group was of great importance and eventually settled on Nga Ringa Aroha (The Loving Hands). With funding from the local hospital board and the district health office, augmented by contributions from various public and private charitable agencies as well as support from the elected marae health committee, a health centre was provided.

In its first year it was staffed by a Maori registered nurse on a part-time basis and the three community members who alternated health centre activities with training, primarily at the local general hospital. The training continued for the better part of a year and included instruction on how to measure blood pressure and glucose and how to make various morphometric assessments. The women were trained to provide guidance on disease prevention and received instruction on nutrition, family planning, rudimentary skills associated with ear care, and maintenance of accurate records. The cooperation of a group of midwives and obstetric nurses allowed an antenatal component to be included.

The women enthusiastically accepted their new roles. They supplemented their basic training by learning to make public presentations, find useful audiovisual aids, assemble and guide group exercise programmes, organize small gatherings for the dissemination of health-related material and, perhaps most importantly, push health concerns to the forefront of everyday life in the community. The proposal for a Maori-orientated, marae-based health programme apparently coincided with similar currents surfacing in other Maori communities, from which delegations began to arrive, anxious to learn and to participate in wide-ranging discussions on health programmes.

From the start, Nga Ringa Aroha initiated outreach into the surrounding community. Regular contact was made with community elders. During visits to the community, blood pressure and/or glucose measurements were made, and, where necessary, people were transported to hospital or practitioners. In keeping with tradition, efforts were made to comfort
people who were suffering and, if requested, to participate in prayers (karakia). This aspect of the work reflected the traditional veneration for the elderly as well as a growing awareness that the adoption of European life-styles had frequently disrupted family ties, isolating the elders and depriving them of support mechanisms and status.

Requests came from community members and public health nurses to transport young children from homes, schools and preschool units to examination and treatment facilities. By maintaining hours well in excess of the basic working week, the women were also able to attend a variety of Maori gatherings at which it was possible to disseminate health-related messages. The measurement of blood pressure became a matter of routine and discussions were initiated on cigarette smoking, alcohol consumption, fitness, diet and nutrition.

In less than two years well over a thousand Maoris of all ages were reached in one way or another. A heightened awareness developed, in and beyond the community, of the possibility of improving health through personal action. Nutrition has become a subject for debate; excess body weight has ceased to be an acceptable norm for many; smoking has become a questionable habit; and the same is true of the consumption of alcohol, particularly during pregnancy.

**Interactions with government health agencies**

*Nga Ringa Aroha* has had to struggle to define its relationship with various long-standing government agencies. Local doctors have not lent their support, and reliance on government departments for salaries and other financial inputs has tended to favour European standards. The tendency of the established health system to view various functions as its own exclusive territory frequently resulted in confusion among the emerging community groups. There is no ready-made slot in the state system for *Nga Ringa Aroha*. Indeed, primary health care is usually regarded as a province of the general medical practitioner. A move to categorize *Nga Ringa Aroha* as a body of health assistants has been vigorously resisted by the women concerned and the marae health committee, who see the new movement as having a significant preventive role and not merely one of doing menial tasks that public health nurses prefer to avoid.

A further example of conflict and misunderstanding between the established medical services and the emerging Maori primary health care workers arose in connection with the ear problems that occur commonly among Maori children. During their hospital training, the members of *Nga Ringa Aroha* were shown how to recognize healthy ears, maintain proper ear hygiene, and detect children in need of medical intervention before the onset of severe pain and irreversible damage. They were eager to share their newly acquired knowledge with the mothers in their community and therefore embarked on a community educational programme that included the use of posters in Maori and English; they prepared a grant proposal for the production of a Maori-orientated videotape, distributed literature, and gave
demonstrations in which otoscopes donated by members of the national health department were used. These activities were frowned on by elements within the medical profession, which apparently considered that ears should be the exclusive domain of the medically qualified. The primary care staff were divested of their examining instruments and instructed to restrict their activities to transporting diagnosed children to practitioners or ear caravans. The protest that many children with ear problems would remain undiscovered until it was too late went unheeded.

Thus there has been a tendency towards the development of conflicting positions rather than cooperation in a joint struggle. The Maori community has received mixed messages as to what can be expected, what it is appropriate to request, and what facilities are likely to be denied or summarily withdrawn. It is worth noting that, in the area studied, the influence of healers who are neither scientifically orientated nor Maori has grown. Dissatisfaction with medical facilities together with confusion about the scope for action of groups such as Nga Ringa Aroha can lead to increased reliance on potentially dangerous alternatives.

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A question arises concerning the degree to which medical and governmental bodies in New Zealand are willing to commit themselves, and the resources they control, to groups such as Nga Ringa Aroha. There was little participation in, encouragement of, or even acknowledgement of the Waahi experiment by medical practitioners. One would hope that a reappraisal of the situation by them would open the way to collaboration with lay groups in the achievement of common goals.

The dearth of medically qualified personnel with Maori roots is a serious problem that should be tackled by government agencies. However, it obviously cannot be solved for many years. The immediate aim should be for practitioners who treat significant numbers of Maori patients to become more sympathetic towards them; cooperation with groups such as the Waahi health centre would be a clear demonstration of good faith. This centre already has a promising record of responding to the health care needs of the Maori community, in terms of the numbers of people reached and, more importantly, of heightened community awareness of the possibilities of improving the quality of life. Attitudes are changing: good health and freedom from avoidable disaster are surfacing as reasonable expectations among Maoris. The realization is dawning that many of the “Maori diseases” are in fact caused by injudicious adoption of the European lifestyle and that they can be prevented.

References


