Marae food gardens - health and wellbeing through urban marae in Tāmaki Makaurau

---

A thesis submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy in Māori and Pacific Health, the University of Auckland, 2017

by
Kimiora Raerino

Abstract

Over many years, and as a result of the legacy of colonisation, indigenous peoples have experienced and continue to experience substantial disparities that have impacted their health and wellbeing. Addressing these complex issues presents health systems with a difficult task given varying lived realities of socioeconomic circumstances, structural issues, and cultural understandings. Current health strategies continue to have limited success for improving indigenous peoples' wellbeing as they remain underpinned by concepts of individualism. Noting these limitations, this thesis argues that cultural-collective approaches that capitalise on existing multifaceted resources within indigenous communities can be more effective and relevant health strategies. Central to the provision of these health programmes is that they are situated and supported by the sociocultural features of urban-indigenous therapeutic landscapes. These are places of indigenous health autonomy as indigenous peoples make decisions about programme outcomes and suitability of resources. Narrowing the focus of this research, I have explored the current circumstances of Māori engagement in community gardens based within urban marae in Auckland, New Zealand.

I employed cultural efficacy theory to determine and analyse how cultural capacity is developed for Māori, and influence of social, cultural and physical environmental factors. Drawing from kaupapa Māori research methods, I undertook face-to-face interviews and group meetings with 34 Māori respondents who were current community gardeners from eight urban marae. My discussions showed that healthy Māori families were a foremost influence and goal of community gardening engagement. Tending the gardens also provided important wellbeing experiences and benefits of social connectedness, altruism and productivity for the Māori respondents within their urbanised lifestyles. Notably, I showed that Māori autonomy, cultural capacity and wellbeing can be increased in the everyday and ordinary practices of gardening within marae. Nevertheless, marae and community gardens face a tenuous future due to external funding and internal participation issues. I found that reflective of diverse urban circumstances neither marae nor community gardens are a priority for all urban Māori. Yet, ultimately I demonstrated that marae and gardens are a comprehensive health promotion activity with multiple holistic benefits that must be considered as just one of many viable Māori health strategies.

Keywords: Māori, Māori health, urban marae, indigenous health autonomy, urban-indigenous therapeutic landscapes, cultural efficacy theory, kaupapa Māori research

Dedication

I dedicate this work to Ngamaru: my father Ngamaru, my son Quaid Ngamaru, and my mokopuna Ngamaru John.

This is also dedicated to my daughter and constant companion: Zantana Kimiora.

Acknowledgements

Along my PhD journey I have had many contributors that I wish to acknowledge and sincerely thank. First and foremost, I would like to thank my study marae and respondents who freely agreed to shared their time and korero with me. I am honoured by your generosity in sharing your gardens, your stories, experiences and knowledge. Your taonga is the heart of this study. He mihi aroha tēnei ki a koutou katoa!

I owe much gratitude to my supervisors, Dr Brad Coombes, Dr Rhys G Jones and Dr Anneka Andersen for their combined support throughout this massive undertaking. My biggest thanks are for my main supervisor Brad – for your expertise, critique, ideas, and encouragement.

On a personal note, I would like to thank all my family members who have supported me in a variety of ways - all of which has been appreciated.

I am thankful for the financial assistance I have received over the years. My biggest financial support came by the way of a Health Research Council project grant - Rangahau Hauora Māori. I thank my HRC team members Panapa Ehau and Rebekah Fuller. Special thanks to Dr Alex Macmillan who inspired and mentored me to start the gardening project and my PhD.

I also acknowledge and thank a number of iwi and Māori organisations for my grants, including: Ngā Pae o te Maramatanga – Post-Doctoral Fellowship, Te Rau Matatini - Henry Rongomau Bennett, Hauora Māori Scholarship, Māori Education Trust; Te Arawa Fisheries Trust, Ngāti Awa Tertiary Grants, Pūtauaki Trust - Ōmataroa Rangitaiki No2, and Uenuku Trust. These grants have been invaluable. Thanks to MAI ki Tāmaki for the peer support meetings, conferences and writing retreats. This support was integral at all stages of my journey. Thanks also to Lisa Morice for proof reading.

My last acknowledgement is to my friends and fellow PhD students Teah Carlson and Anna Fay, thank you both so much for your support throughout this entire journey.

Again, to everyone here, thank you all.

Figure 1: Mataatua Marae 1

Reviewing the māra kai of my urban marae with Whaea Rangitahi

Table of Contents

List of Tables

List of Figures

All photographs have been published herein with the signed consent of both the marae and respondents (see Appendix F)

Chapter 1 Introduction

This thesis argues that specific indigenous sociocultural settings, namely culturally-loaded places, have a distinctive role in supporting cultural-collective initiatives that produce multi-faceted wellbeing outcomes. Culturally-loaded places[1] can be broadly defined as traditional gathering places for indigenous peoples that are supported by their cultural foundations and textured by human movement and action, identities, and relationships (Wen Li, Hodgetts, & Ho, 2010). In New Zealand, marae represent culturally-loaded places where Māori can gather and where the fullest expression of Māori life and culture is upheld and practiced through tribal customs, values, and traditions (Tapsell, 2002; R. Walker, 1975). They are a crucial support for Māori wellbeing and health activities due to their function as a 'Māori place of being' where culture is centralised, empowered and practised. Indigenous empowerment is a significant feature of culturally-loaded places, where indigenous peoples control and determine the wide-ranging social and cultural activities held within. Hence, in the following chapters, I argue that health systems need to further support the development of cultural-collective approaches that draw from and capitalise on culturally-loaded places and their associated features of empowerment. In order to demonstrate the important and distinctive role of culturally-loaded places, I use the cultural-collective activity of community gardens located within urban marae as a platform. I selected marae community gardens because they encompass a broad range of sociocultural and environmental features that can provide increased understandings of the effective combination of cultural-collective health programmes and specific indigenous health settings. Notably, I show that marae gardens also have an important role in developing cultural efficacy as the gardeners' cultural capacity is enhanced by the dynamic relationship between their sociocultural settings, cultural features and interactive experiences. The development of cultural efficacy has important potential repercussions for indigenous peoples' wellbeing because it enables cultural group confidence to address local health issues. Accordingly, I argue that community gardens within marae represent an ordinary everyday activity that can result in subtle but significant cultural-collective wellbeing outcomes. These multi-faceted benefits and empowering aspects of cultural capacity, sociocultural connectedness and cultural reinvigoration are not readily available in other health settings.

This study is necessary for many reasons. Foremost are the prevailing concerns for indigenous peoples' health and wellbeing which highlight the necessity of fostering multiple wellbeing strategies. Indigenous peoples around the world experience significantly poorer health outcomes than their non-Indigenous counterparts (Axelsson, Kukutai, & Kippen, 2016; M. Durie, 2012; K. Wilson & Richmond, 2009). Long-term issues of ill health and health inequities between indigenous and non-indigenous populations are well documented (Kirmayer & Brass, 2016; Walters et al., 2016). More recently, the increasingly diverse living circumstances and requirements across both urban and rural populations of indigenous peoples have resulted in a complex combination of long-term and new health issues (Alegria, Atkins, Farmer, Slaton, & Stelk, 2010; S. Henderson & Kendall, 2011). Within indigenous communities there is diversity in health, economic, social, and cultural circumstances. This situation

[1] For a more detailed explanation of 'culturally-loaded places' refer to my terminology appendix

elevates the importance of ensuring that health systems offer extensive indigenous health services and programmes. Developing indigenous health strategies today can be challenging because programmes need to target competing determinants of health, both structural and environmental, which can be difficult for conventional health systems to address (Dutta, 2016; Richmond & Cook, 2016). As I will discuss below, health academics contend that mainstream health programmes can fail due to an over-reliance on biomedical models of health alongside 'victim blaming' and 'one-solution-for-all' approaches (Airhihenbuwa, Ford, & Iwelunmor, 2014; Bond, Brough, Spurling, & Hayman, 2012). The focus of these programmes centres on persuading individuals to change behaviours, while ignoring the cultural influence of family and associated values. Further, limited attention is given to the effects of structural or societal influences including social, economic and political processes (Lardon, Wolsko, Trickett, Henry, & Hopkins, 2016; Tengland, 2016). Significantly, contributors to the indigenous health literature are emphasising the need to remodel health services to include collective-cultural approaches which prioritise features such as family and cultural connectedness (H. Anderson & Kowal, 2012; Hartmann, 2016). This approach is beginning to contribute to the design and delivery of health services that are more consistent with the norms and values of indigenous peoples.

Whilst cultural-collective approaches involving indigenous peoples are progressively gaining support from health systems, the contribution of culturally-loaded places has received less attention. Yet, the emergent literature indicates that specific indigenous settings can contribute significantly to wellbeing initiatives by facilitating experiences of cultural and land connectedness, while providing access to sociocultural resources (Goodkind, Gorman, Hess, Parker, & Hough, 2015; Marquina-Márquez, Virchez, & Ruiz-Callado, 2016; J K Tobias, 2015). The significance of these experiences of sociocultural connectedness for indigenous wellbeing is intensified for urban-indigenous people who have moved into cities and may no longer live or engage within their tribal communities. As I demonstrate in Chapter 3, this reinforces the important role of culturally-loaded places in urban centres. Here they can be aligned to urban-indigenous therapeutic landscapes as places in which indigenous peoples can be among fellow indigenous peoples and immersed in their culture while undertaking health initiatives (see Wendt & Gone, 2012a). Placing community gardens within culturally-loaded places enables indigenous people to contribute to their families' nutritional, social and cultural wellbeing. Gardens encompass features of empowerment and autonomy as the gardeners utilise their skills to collectively grow produce and engage in localised food initiatives for collective wellbeing (Cidro, Martens, & Guilbault, 2016; Rudolph & McLachlan, 2013). Alongside learning experiences, the gardeners are actively accomplishing goals while simultaneously increasing their capacity and confidence. Within the sociocultural settings of culturally-loaded places, gardeners can further develop their cultural efficacy beliefs as they interact with and witness other tribal members at work. These empowering environments and activities are crucial for the autonomy of indigenous peoples as they regain control of their health and health services. Unfortunately, as I show later, while indigenous communities have become increasingly empowered in self-determining their health services, neoliberal constraints are undermining these efforts (Brown, McPherson, Peterson, Newman, & Cranmer, 2012; Browne et al., 2016). Nonetheless, as a testament to the resilience and resolve of indigenous peoples, many communities continue to persevere and adapt in providing or supporting their own health services and improving their community's health.

Throughout the thesis, I show how cultural-collective health approaches utilising the distinctive features of culturally-loaded places can effectively contribute to improved indigenous wellbeing. Central to this indigenous health research is the development and utilisation of cultural frameworks that identify the necessary features and supports of collective empowerment and indigenous autonomy. Conventional health behaviour theories are predominately individualised constructs that lack relevance to the cultural-collective inclinations of many indigenous peoples. This thesis employs cultural efficacy theory as a framework for understanding the factors that influence and contribute to the outcomes of indigenous peoples' engagement in wellbeing activities. As I further discuss in Chapter 2, the foundations of this framework are located within Bandura's (1986, 2000a) social learning theory which demonstrates that environmental and social factors influence self-beliefs around capacity and ability. Yet, Bandura's conceptual frameworks are limited to understandings of self- and collective efficacy. Moreover, while these two theories recognise the impact or influence of environmental factors, individualised cognitive factors are given higher priority for influencing behaviours. I maintain that for many indigenous peoples, the factors that influence their efficacy beliefs are neither solely individually nor collectively motivated, but rather equally combined in cultural-collective factors. Hence, I argue that cultural efficacy theory is applicable as a framework because it recognises the important relationships between sociocultural environments and their associated features as integral to the development of cultural efficacy beliefs and subsequent wellbeing. This framework is applied to the circumstances and perspectives of Māori gardeners involved in community gardens at eight marae in Tāmaki Makaurau (Auckland), New Zealand. Culturally efficacy theory provides an important framework that, I will show, emphasises and supports my argument that marae have a distinctive role in the holistic wellbeing of urban Māori.

In Section 1.1 and 1.2, I provide further justifications for this research. First, I provide an overview of indigenous health issues and highlight some of main debates and emerging understandings of possible solutions. I argue that marae food gardens can offer fresh understandings of the empowering aspects of indigenous health settings in producing multiple wellbeing outcomes. Second, I highlight the significance of this thesis in contributing towards improved indigenous health. Next, in Section 1.3, I briefly describe my research objectives which serve to identify the potential of culturally-loaded places and community gardens. Finally, in Section 1.4, I provide a summation of my thesis structure and how this format supports the presentation of my argument.

1.1 Determining indigenous health and wellbeing

The United Nations has estimated there are approximately 370 million indigenous peoples in the world, living in over 70 countries (United Nations, 2011). While there is enormous cultural diversity in indigenous languages and practices, there is an unfortunate commonality of persisting inequities in health. This burden of poor health among indigenous peoples is a major challenge for health systems worldwide (Axelsson et al., 2016; Dew, Scott, & Kirkman, 2016; Mitrou et al., 2014). The causes of ill-health have generally been associated with high rates of poverty, poor living conditions, environmental

contamination, and restricted access to fresh nutritional food. Other causes have been attributed to rapidly evolving diseases with complex and multidimensional origins, such as obesity, high blood pressure, type 2 diabetes, and cardiovascular disease (Huffman & Galloway, 2010; Stoner et al., 2015). While living conditions and lifestyle factors have affected the wellbeing of indigenous peoples, studies demonstrate that the root causes of poor health resulting in significant health gaps are much more complex (A. J. Browne et al., 2016; Gracey, 2014). Health researchers have argued that the most significant influences on the prevailing state of indigenous health stem from a legacy of colonisation and urbanisation processes (Brand, Bond, & Shannon, 2016; Kirmayer & Brass, 2016; Paradies, 2016). These historical and contemporary processes have comprehensively affected the wellbeing of indigenous peoples by influencing determinants that underpin inequitable health outcomes. Hence, improving indigenous peoples' health is a critical but an increasingly complex challenge.

Health systems must now address the contemporary realities of indigenous health and wellbeing, including individual and community-based effects of health disparities and the direct and indirect sources of those disparities (Adelson, 2005; Richmond & Cook, 2016). Past health promotion efforts to improve indigenous health have been largely ineffective due to their westernised underpinnings which centre on a scientific, individualistic and biomedical approach to ill health (Goldberg, 2012; Sasakamoose, Scerbe, Wenaus, & Scandrett, 2016). This conventional health approach has been supported by information-based health education programmes which have had limited effects on behaviour change across countries and contexts (see further Chapter 3). Research has also shown indigenous wellbeing continues to be negatively affected by experiences of individual and systemic discrimination when seeking health care, despite purported efforts within health systems to promote culturally sensitive services and programmes (A. J. Browne et al., 2016; Gerlach, Browne, & Greenwood, 2017). Health academics argue that the challenges of the current indigenous health crisis necessitate strategies that are more upstream, culture-centred, and pluralistic (Dutta, Anaele, & Jones, 2013; Wilk & Cooke, 2015). Others contend that health programmes are more successful and sustainable when they comprehensively involve indigenous community members, local knowledge and leadership (S. C. Thompson et al., 2015; Roz Walker, Schultz, & Sonn, 2014). These recent studies demonstrate the need to further develop indigenous health initiatives that incorporate a cultural-collective approach which includes local knowledges and resources.

Notwithstanding, indigenous leaders and academics maintain that any efforts to address health issues must be based on understandings of the effects of disempowerment across consecutive indigenous generations (M. Durie, 2005; Kirmayer & Brass, 2016; Paradies, 2016). This includes the undermining of control in cultural knowledge, land, self-determination, housing, and health care. The consequences of indigenous peoples' disempowerment have historical foundations affecting health that continue today. Contributing to these experiences of disempowerment are health strategies that remain predominantly initiated externally from indigenous communities, often targeting individual behavioural change with little regard for social determinants or cultural needs (Aniza & Norhayati, 2016; Nesdole, Voigts, Lepnurm, & Roberts, 2014). Health researchers maintain that 'external' strategies are problematic for many reasons when governmental organisations determine a community's health

‘problem’ and then provide fixed solutions or advice that is often unsolicited or incongruent with their socioeconomic living circumstances (McPhail-Bell, Bond, Brough, & Fredericks, 2015; Waterworth, 2015). External strategies also perpetuate experiences of disempowerment within indigenous communities when imposed health programmes reinforce the power and privilege of the state by dictating how communities should live and, further, they are criticised for not living in a certain manner (McPhail-Bell et al., 2015). As a means of resolving these issues of disempowerment and the increasingly complex health needs of indigenous communities, emerging studies are demonstrating that a ‘health settings’ approach of empowering the autonomy of indigenous communities in undertaking their own health programmes is required (Smylie et al., 2016; Walters et al., 2016). Empowered indigenous communities can utilise local knowledge of locational context and health challenges to achieve collectively determined goals.

Indigenous health leaders have argued that localising health initiatives contributes to the empowerment of indigenous communities as they deliver programmes based on community strengths, assets and capacities (Demaio, Drysdale, & de Courten, 2012; M. Durie, 2004). Recent studies demonstrate that indigenous health promotion initiated within their communities is more culturally congruent because it incorporates features such as cultural concepts and values (Basu, Dillon, & Romero-Daza, 2016; Ziabakhsh, Pederson, Prodan-Bhalla, Middagh, & Jinkerson-Brass, 2016). Current programmes, exampled within Native American or First Nations communities, have further adapted or refocussed to include traditional tribal practices and experiences that encourage cultural reinvigoration and intergenerational knowledge transmission (Gone, 2011a; Sasakamoose et al., 2016). Many of these programmes have achieved proven results for indigenous youth, particularly in the areas of substance abuse and suicide (DeCou, Skewes, & Lopez, 2013; Friesen et al., 2015). Taken together, these studies confirm that indigenous community situated and initiated health programmes facilitate many health and wellbeing benefits. Notably for this study, empowering indigenous communities contributes to the development of their cultural capacity as they make decisions and actions leading to positive outcomes for their cultural-collective wellbeing. This also encourages community ownership of health initiatives and the involvement of local people ensures programmes receive local endorsement and support. Successful indigenous health promotion can be characterised by a high level of community engagement which is built on local knowledge about what works and what are likely to be acceptable practices and outcomes.

Situating health promotion within indigenous communities provides an opportunity to centre health care within a setting that ensures ease of access to services, and the provision of culturally appropriate programmes that can be adapted to reflect the realities of indigenous life (Wendt & Gone, 2012a). Further, by placing the control of health services within indigenous communities, stakeholders are empowered to develop wellbeing strategies linked to the recognition and advancement of their cultural foundations, while also focusing on equity of health outcomes. The physical venue offers opportunities for (re)connection with tribal members and land, and therapeutic experiences of place, which contribute to wellbeing (Hartmann, 2016; Redvers, 2016). For urban indigenous population groups, the physical venue and programmes can also present an opportunity to establish links to new land and pan-tribal relationships (Wendt & Gone, 2012a). Connection to land is intricately linked to

maintaining vital cultural foundations such as identity, knowledges, and practices (Christensen, 2013; J K. Tobias & Richmond, 2014). For many indigenous peoples, the physical and spiritual interaction with land is viewed as a means of reconnecting with ancestry and creating a sense of belonging (H. J. Brown, McPherson, Peterson, Newman, & Cranmer, 2012; Kingsley, Townsend, Phillips, & Aldous, 2009). The experience of such interactions within specific indigenous settings, in particular culturally-loaded places, contributes to cultural-collective wellbeing. In this regard, community gardens located within these settings can provide increased opportunities for environmental and sociocultural connectedness, alongside features of autonomy and increased cultural efficacy.

Numerous studies have demonstrated that community gardens are multifunctional sites providing education, recreation and holistic healing opportunities for their community (J. R. Brown, 2012; Earle, 2011; Pitt, 2014). Community gardens represent a productive and empowering space for individuals to develop capacities as ecological citizens, organise around garden and neighbourhood advocacy, and become engaged in collective action on community issues such as food security (Okvat & Zautra, 2011; Pudup, 2008). Yet, community gardens are a paradox because although they represent a food system opposed to the notion of neoliberalism, they end up re-subscribing to it in practice (Guthman, 2008). This is because gardeners who are committed and persevere to sustain their gardens can become complicit in the construction of neoliberal hegemony by acting as neoliberal subjects who alleviate government from social service provision (Ghose & Pettygrove, 2014a). In other words, as civic engagement in community gardens increases, the 'welfarist' functions of the state reduce (Rosol, 2012). This politicised feature of community gardens is further heightened by their role in everyday grassroots activism within disadvantaged communities (Block, Chavez, Allen, & Ramirez, 2012; J. R. Brown, 2012; Milbourne, 2012). In a recent study, Milbourne (2012) argued that community gardens re-shape lived spaces in social and ecological terms through varying scales of action and meaning as they address issues of injustice experienced by community residents. These issues include economic, sociocultural, political and environmental processes that affect their everyday lives. Interestingly, emerging studies maintain that community gardens are neither wholly radical or neoliberal, but rather a hybrid that operates on multiple scales (McClintock, 2013). In this regard, as I show in Chapter 4, community gardens located within culturally-loaded places can be viewed as an everyday political activity encompassing both neoliberal and radical factors. Depending on the outcomes, these experiences can ultimately contribute to increased or decreased capacity within indigenous communities.

Nonetheless, indigenous health studies highlight the multifaceted benefits of community gardens as a grassroots initiative that holistically improves family wellbeing (Cidro, Adekunle, Peters, & Martens, 2015; Gendron, Hancherow, & Norton, 2016; Shirley Thompson, Kamal, Alam, & Wiebe, 2012). Although community gardens can be considered small scale initiatives, the holistic benefits, including their unique contribution to the retention of traditional foods and practices, are significant. Alongside the physical and nutritional benefits, productive gardens can improve the wellbeing of gardeners through a sense of achievement and feeling closer to family members and nature. This health initiative, located within indigenous peoples' communities, offers an alternative wellbeing strategy that centres on subtle health improvement for the family, as opposed to the often dramatic health changes

promoted in individualised and information-focused conventional health programmes. Further, marae offer sociocultural support for garden initiatives as they are informal spaces for cultural-collective engagement and outcomes. They can also provide an empowering space of Māori control separate from the often repressive and individualised urban and colonial external environment (see further Chapters 3 & 5). As mentioned in the preceding section, community gardens provide a physical place for gardeners to mobilise and accomplish collective goals to benefit their families and the marae. Health promotion strategies centred on ordinary activities like community gardens increase and strengthen the cultural capacity of indigenous peoples and so the success of the strategies (P. King, Hodgetts, Rua, & Te Whetu, 2015). These cultural collective initiatives should be included within a diverse range of health strategies that endeavour to address the complex living circumstances and cultural understandings of urban indigenous population groups.

In sum, despite the concepts of ‘health settings’ and 'culture-centred’ approaches receiving more attention within health promotion studies (Airhihenbuwa et al., 2014; Larkey & Hecht, 2010), little is currently known about the workings of indigenous-specific health settings and their programmes for improved collective wellbeing. Fortunately, a very recent exception is King’s (2015) research which showed that everyday gardening practices on a marae for a group of homeless urban Māori men contributed to their wellbeing through experiences of respite, reconnection, a sense of belonging, and remembered Māori ways of being. Despite this recent local example of a culture-collective initiative in an urban-indigenous health setting, there is an absence of similar studies that highlight features of indigenous empowerment. This gap severely restricts the extent to which the combined benefits of empowerment within indigenous health settings and their wellbeing programmes can be documented and disseminated, and the main factors impeding the success of these programmes identified. An in-depth study provides a potentially useful starting point for conceptualising empowerment features of indigenous communities that serve to support and enhance their autonomy and most likely improve collective wellbeing. Hence, in this study, I aim to extend knowledge of the role of indigenous health settings and features of empowerment in health programmes that provide holistic culture and collective benefits.

In the upcoming chapters, I argue that health strategies need to further develop cultural-collective approaches that draw from and capitalise on culturally-loaded places and their associated features. This also involves consideration of cultural theoretical frameworks that prioritise indigenous peoples’ cultural-collective inclinations and environmental influences that can increase or impede their wellbeing. Whilst some evolving health strategies have begun to incorporate settings and culturally appropriate programmes, the full utility and potential of culturally-loaded places remains mostly unrealised. The necessity of utilising appropriate health promotion settings, such as marae, is underpinned by the capacity of these places to act as both producers and products of indigenous peoples’ empowerment. By highlighting the circumstances and discussions of Māori gardeners tending gardens within urban marae in Tāmaki Makaurau (Auckland, New Zealand), I will demonstrate how cultural-collective health approaches within indigenous settings can effectively contribute to improved indigenous wellbeing. In light of the ongoing poor health and wellbeing circumstances of

indigenous peoples, further evidence is needed to support new approaches for holistic health services and programmes.

1.2 Significance of the study

This thesis contributes knowledge and understandings within the fields of Māori and indigenous peoples' health and wellbeing. The discussions and examination of culturally-loaded places and cultural-collective approaches linked to wellbeing have practical, theoretical, and personal significance. The practical significance centres on the knowledge gained by investigating the multi-faceted circumstances and workings of health initiatives generated and situated within indigenous communities. In this regard, marae in New Zealand represent a comprehensive health site that can deliver programmes that are community initiated, situated, controlled, and supported. Marae can choose to incorporate both governmental and marae led programmes in their health services, and keep them fundamentally within marae control.

The significance of this study is the lessons arising from a focused analysis of indigenous health promotion, indigenous multi-level engagement and the supporting role of culturally-loaded places, as exemplified by urban marae and Māori. My research provides information from eight marae and draws on the insights of Māori gardeners. This study was specifically designed to gather data regarding participants' motivation and engagement within their marae setting. This knowledge will assist health systems by elucidating the contexts in which people choose initiatives such as community gardens as a method of improving and maintaining family and cultural health. Notably, the selection and examination of community gardens as the health initiative has practical relevance because it is an everyday ordinary activity that encompasses features of collective autonomy, while also providing valuable opportunities for intergenerational sociocultural knowledge exchanges (A. Hume, K. O'Dea, & J. K. Brimblecombe, 2013; Milbourne, 2012). As I demonstrate in Chapter 5, governmental family-based initiatives such as Whānau Ora (see Te Puni Kōkiri, 2012a) have grown in popularity in New Zealand. It is essential that health professionals are conversant with the practicalities of initiatives that are already in progress as Māori endeavour to undertake their own strategies in holistic health improvement. This study can contribute to public policy by providing evidence of collective wellbeing outcomes derived from the ordinary activity of gardening and the exercise of autonomy in marae gardens.

This thesis also makes a contribution to the development of a theoretical framework that provides understandings and analysis of indigenous peoples' health motivations and behaviours. As mentioned in the preceding section, cultural efficacy theory, the conceptual framework employed in this study, moves beyond individual and collective factors in an attempt to understand behavioural influences. Bandura's (1985) theory of triadic reciprocal determinism primarily supports the notion that an individual's behaviour both influences and is influenced by personal factors and the social environment. In recent years, Bandura and others have extended self-efficacy theory to reflect the collective tendencies of people who engage or are influenced by social environments and factors in

achieving group defined targets and goals (Bandura, 2000a; R. J. Sampson, 2003; Stajkovic, Lee, & Nyberg, 2009). Yet, as I argue in Chapter 2, a shortcoming of these earlier conceptions of efficacy is their failure to take into consideration the cultural inclinations or motivations of indigenous peoples and the influence of specific sociocultural settings. Indigenous peoples' behaviour or behavioural change may not be motivated by personal or collective influences alone, but may also be attributable to cultural motivations (Airhihenbuwa et al., 2014; Mundel & Chapman, 2010). As their cultural ability and capacity develops or increases, their confidence in addressing the needs and goals of their own indigenous group is enhanced. Yet, as cultural ability increases so too does the awareness of cultural challenges, including awareness of experiences of marginalisation and cultural dispossession (Houkamau & Sibley, 2011). While cultural frameworks for understanding indigenous motivations and behaviours are not new, the cultural efficacy framework supports consideration of the dynamic relationship between indigenous peoples and their environments in the development of cultural efficacy.

Finally, this thesis has personal significance. For many reasons, research into the role of urban marae in the health and wellbeing of Māori has personal implications for me. As a current member of an urban marae, I have taken on the responsibility of providing an in-depth study of Māori health and the workings of marae, including the motivations, benefits, and issues of wellbeing initiatives. After the completion of the research interviews for this study and during the write up, I revisited all my case marae. One of my marae respondents, Wyn (Follow up group interview, Wyn, Nga Whare Waatea Marae, 26 September 2013), succinctly reminded me of the importance of this work:

> … this is an acknowledgement of good work, you know and your mahi (work), to capture these conversations, because we would have lost it … We wouldn't have sat down in this way necessarily, the three of us and shared some of our insights as formally - it wouldn't have been captured. We might have done it and said what a good project that was, and then sat down and waited around for the next project to come along, but you've actually 'called it' for us, and that's valuable, and acknowledged …

This research is the culmination of my ongoing interest in the dynamic nature and utility of urban marae and my fundamental perception that marae experiences can be a positive means of developing holistic wellbeing. My first experience of (re)connecting with my urban marae began with my Master's study in which I examined the role of urban marae in maintaining a tribal identity away from traditional lands. As I have pursued knowledge and understandings of marae and their workings, my own views have been shaped and transformed in the process. Paradoxically, I find marae can be both comforting and confronting. As I discuss further in Chapter 6, I am an urban Māori with limited language and cultural knowledge. While I have had largely positive marae experiences and interactions, there have also been difficult times due to my cultural inexperience and unfamiliarity. Over my years of marae involvement, I have appreciated the positive experiences of my continued engagement that have developed strong family and cultural connectedness. Yet, this is tempered with personal understanding that marae environments and experiences can be notoriously difficult to navigate and

withstand for newcomers and returning members alike. I have spent time on a marae committee as we have strived to produce effective initiatives that (re)connect other tribal members to our marae, often with limited success. The significance of this research can serve to highlight the function of marae, their wellbeing programmes and intentions, and even more importantly, what compels Māori to engage and participate with marae.

Interestingly, the inspiration for this thesis arose from a visit to Papatūānuku Kōkiri Marae for a prior research project and specifically my interview with marae stalwart, Hineamaru Ropati. Following the interview, she took me on a tour of the large marae gardens as she spoke of the ethos and workings of their marae-based community gardens. The enthusiasm of Hineamaru for the marae gardens and their potential was matched by the many gardeners we encountered. My personal and research interest was piqued: why were so many Māori community members here working in the gardens? What were the benefits for them and the marae? What were the personal, family, or cultural factors motivating these gardeners to engage? Essentially, what role did the marae play to entice their participation? The exploration and answers to these questions have significance, not only for my marae, and indeed all the study marae, but also for broader regional and national interests. As I deliberated the answers and possibilities, I could see avenues for the reinvigoration and empowerment of marae and Māori health. Marae today are struggling for consistent Māori involvement and support and are therefore in a state of disrepair (Tapsell, 2014). Māori academics have shown that weakening connections to marae are having a ripple effect through Māori communities in terms of cultural connectedness, continuity and wellbeing (George, 2012; M. Kawharu, 2010). The outcomes of this thesis will have specific implications for marae regarding how they are supported and utilised in the future by health systems and local community organisations. The current reality that a large majority of marae throughout New Zealand are struggling in terms of active Māori participation and governmental support emphasises the importance of this research.

1.3 Research aims and objectives

My central argument is that indigenous health can be improved through the effective utility of culturally-loaded places as supports for holistic cultural-collective initiatives. I selected both marae and community gardens because they present an empowered indigenous setting and activity with distinct multifaceted benefits. As I discussed in Section 1.1, a significant feature of these places is that indigenous peoples control and determine the sociocultural activities and the intended outcomes. These features of empowerment are integral to the effectiveness and appropriateness of future health system strategies. The specific aim of this thesis is to better understand the role of culturally-loaded places as autonomous environments to support wellbeing initiatives, and how they can contribute to the development of cultural capacity and wellbeing for indigenous peoples. The thesis hypothesis is that marae are an important example of the significance of specific environmental influences for cultural efficacy beliefs and Māori wellbeing. Efforts to improve indigenous health and wellbeing need not rely on contracted or high-level health system initiatives, but can be centred on everyday cultural-

collective activities such as community gardens supported by culturally-loaded places. Hence, my central research question is:

> What are the preconditions for addressing indigenous health problems and to what extent can participation in community gardens on culturally-loaded places satisfy those conditions?

My research question is supported by the following objectives:

- To examine the relationship between cultural efficacy and everyday activities within culturally-loaded places;
- To identity and examine the outcomes derived from participation in marae food gardens and their implications for elevating indigenous wellbeing;
- To explore the importance of site and locational context in the delivery of effective and appropriate indigenous health promotion.

Of note, my thesis research initially began as a focused examination of Māori engagement in community gardens within urban marae that were government funded by a Te Puni Kōkiri health initiative, 'Maara Kai' (see further Chapter 6). However, during the pre-recruitment phase after contacting marae with gardens to introduce the study, I very quickly discovered that few marae had exclusive Te Puni Kōkiri funding. Indeed, the majority of marae contacted had commenced their gardens supported by a mix of sources including: local councils; marae and personal funding; and iwi (tribe) funding. Unsurprisingly, most of these marae gardens were struggling to remain active due to variable and inconsistent funding. This did not detract from the research objectives that I set out with; rather, it subsequently allowed for a more in-depth analysis of the marae gardening stories regarding Māori and marae empowerment and autonomy.

1.4 Structure of thesis

This thesis is organised into ten chapters, each of which addresses a specific aspect of the study and contributes to the arguments developed. In Chapter 2, I discuss the necessity of applying a cultural efficacy framework to understand the motivations of indigenous people in the development of cultural capacity and wellbeing. I argue for and emphasise the importance of moving beyond individualistic or collectivistic theories for determining indigenous people's motivations and that cultural-collective frameworks have more applicability. In Chapter 3, I explore indigenous health promotion and review the necessary features required to provide a comprehensive cultural-collective approach for indigenous health promotion. I argue that situating health promotion within indigenous communities and capitalising on the many sociocultural features within these settings can influence wellbeing. Then, in Chapter 4, I demonstrate that community gardens can produce holistic benefits including the empowerment of indigenous peoples. Gardens also have an increasingly important political role for indigenous communities, within alternative food and food sovereignty movements. I argue that gardens are empowering everyday settings that develop cultural efficacy and wellbeing. In Chapter 5, I provide context on the health circumstances of Māori that have evolved over many decades. I

highlight the detrimental effects of specific colonising processes that have undermined the cultural-collective foundations of Māori. I then review New Zealand's health reforms and the development of the Whānau Ora strategies to empower Māori health systems. I also provide context for my case study, showing why an investigation of urban marae and community gardens is useful for understanding the development of Māori cultural efficacy and wellbeing. Chapter 6 outlines my methodological framework, arguing for the importance of utilising indigenous methodologies such as kaupapa Māori Research when conducting a qualitative inquiry involving Māori and marae.

The next three chapters are discussions based on my empirical research. Chapter 7 demonstrates community gardening as an ordinary and familiar collective activity that, when located and undertaken on marae, contributes to the empowerment of Māori autonomy. I suggest that the everyday activity of gardening within marae produces multi-faceted benefits for wellbeing which are subtly reinforced and supported by the cultural-collective settings. I also reveal the dichotomous nature of community gardens in reinforcing and resisting neoliberalism. Yet, overall, it is a comprehensive health promotion activity that can develop Māori cultural efficacy. In Chapter 8, I demonstrate that sociality is one of the leading influences and outcomes of marae gardening engagement. While altruism and productivity were also identified as essential preconditions for Māori wellbeing, socialising was the most significant attribute. Māori wellbeing is affected by social isolation and reduced intergenerational interactions within urban centres and I show how social factors compelled the respondents to engage in the marae community gardens. By connecting and sharing among family within a Māori cultural context, the gardeners were actively enhancing their sociocultural connectedness, knowledge, and wellbeing. In Chapter 9, I assess the practical role and features of urban marae that underpin their importance as a cultural-collective setting for Māori health and wellbeing. I show that marae are both products and producers of Māori empowerment. Throughout the chapter, I demonstrate that urban marae can be situated with urban-indigenous therapeutic landscapes as a familiar place to be among Māori and culture while mobilising and engaging in wellbeing activities. Marae represent a vital cultural foundation for Māori. Nevertheless, more work needs to be undertaken to reinvigorate and (re)connect urban Māori to their marae so that both Māori and marae wellbeing can be improved. Lastly, Chapter 10 highlights and reviews the contributions of my research, reflecting on the consequences of the research undertaken and suggesting further avenues of investigation.

Figure 2: Ōrākei Marae 1

Auckland City Mission information sign located on Ōrākei Marae

Chapter 2 Cultural efficacy theory

2.1 Introduction

In this chapter, I argue that cultural efficacy theory provides a framework by which to understand the essential components required for effective and appropriate health promotion within indigenous communities. It moves beyond both individualistic and collective frameworks to provide a culture-centred construct for determining how indigenous peoples' wellbeing can be increased, what the preconditions are for indigenous wellbeing, and where the essential supports for these preconditions can be located. At a foundational level, this framework validates the importance of cultural and collective experiences and interactions within culturally-loaded places as conducive to improved indigenous wellbeing, which is relevant to my study of urban marae and Māori. I support my argument by presenting the development of efficacy theories from self- to collective and then to cultural, and reviewing the effectiveness of each of these theories in relation to the requirements and circumstances of indigenous peoples' health and wellbeing. I will demonstrate that efficacy beliefs, such as confidence and ability, influence wellbeing behaviours. For indigenous peoples, increased cultural efficacy can contribute to their motivation to actively engage in collective wellbeing initiatives.

First, in Section 2.2, I present a review of self-efficacy theory and the work of Albert Bandura in the development of this construct. Bandura (2003) claims that every person has beliefs concerning competence in specific situations that influence choice, performance, and persistence in endeavours. The development of these beliefs can affect individual health behaviours and, consequently, wellbeing. Bandura described four main information sources that influence people's beliefs and I highlight the role of the environment within his model of triadic reciprocal determinism. Studies have shown that the dynamic relationship between personal, environment and behavioural factors contributes to the development of efficacy beliefs and wellbeing (D'Angelo, Pelletier, Reid, & Huta, 2014; Fitzgerald, Heary, Kelly, Nixon, & Shevlin, 2013). However, I show that Bandura's theories are limited to individual and collective factors, which may not be compatible with the culture-collective motivations and requirements of indigenous peoples. Moreover, while environmental factors are emphasised as essential in the development of self-efficacy beliefs, I posit that Bandura prioritises cognitive influences and minimises many environmental influences such as structural determinants. This further adds to the incompatibility of self-efficacy theory to the requirements of indigenous peoples. Cultural efficacy, on the other hand, prioritises the influence of indigenous peoples' sociocultural environments and associated factors as a significant feature in the development of cultural efficacy beliefs and wellbeing.

In Section 2.3, I examine collective efficacy theory by highlighting the work of Bandura and others who have contributed to this expanded framework. The central tenet of collective efficacy is the connection between group beliefs and group behaviours. Social environments are vital to the development of collective efficacy. Again, I review the current application of collective efficacy in health programmes and then determine its applicability for indigenous people. I contend that while this theory has stronger

relevance for indigenous peoples than self-efficacy, it does not incorporate nor prioritise cultural factors essential for indigenous wellbeing. Finally, in Section 2.4, I explore and describe the determinants of cultural efficacy. I demonstrate that by understanding the influence of cultural efficacy within culturally-loaded places, an invaluable insight can be gained into how best to encourage and facilitate indigenous participation in specific activities that lead to improved health outcomes. While this is not a definitive framework or solution for the diverse circumstances of indigenous peoples, it provides a means of identifying and supporting solutions within indigenous communities. Identifying solutions situated within indigenous communities leads to my next chapter in which I present my argument that health systems can effectively utilise cultural efficacy as a cultural framework for providing effective and applicable wellbeing initiatives within indigenous communities.

2.2 Self-efficacy theory: a construct of self-capability

The use of theoretical models and constructs is critical for understanding influences on behaviour and for guiding health initiatives. One of the most prominent theories applied to health behaviour research is psychologist Albert Bandura's (1977, 1997, 2000b) self-efficacy theory. This theory primarily refers to beliefs of self-capability, and argues that the stronger an individual's beliefs in their abilities, the more likely he or she can succeed in situations or achieve goals. Therefore, self-efficacy can be an important prerequisite for behaviour change. Since the conception of self-efficacy theory several decades ago, a wide range of studies has applied this framework to individual behaviours (Schunk & Pajares, 2009). The range of research domains utilising this theoretical framework has been extensive, and includes such areas as education (M. J. Boulton, 2014), careers (Imbellone & Laghi, 2016), athletics (Samson & Solmon, 2011), and health (French, 2015). In accordance with the construct of self-efficacy, the research focus has typically emphasised individual agency, primarily self-belief, within varying environments and activities as a means for behaviour change and improved wellbeing (Maddux, 2012). The belief in one's ability to successfully carry out a given course of action to attain the desired outcome is pivotal to improved health behaviours. Health studies have consistently demonstrated that behaviour change is influenced by an individual's self-confidence and capability, which develops from an interdependent relationship between environmental and personal factors (Barber, 2013; L. L. Lee, Kuo, Fanaw, Perng, & Juang, 2012). Self-efficacy theory explains people's behaviour through cognitive constructs and environment influences. Below, I provide a brief history of the conception self-efficacy theory, as developed by Bandura from social learning theory as an alternative to traditional learning theory. I also show how efficacy beliefs are developed from environmental information sources. Ultimately, Bandura's theory places emphasis on cognitive, personal and environmental factors for understanding behavioural change.

2.2.1 The origins of self-efficacy theory

Self-efficacy theory originated within social cognitive theory which was developed from social learning theory. Social learning theory emphasised that if an individual is motivated to learn a particular

behaviour then that behaviour is learnt through clear observations. By imitating and modelling these observed behaviours within social contexts, people can learn through positive reinforcement (Miller & Dollard, 1941). In 1963, Bandura and Walters' *Social Learning and Personality Development* broadened the boundaries of social learning theory with the addition of two principles: observational learning and vicarious reinforcement (Bandura & Walters, 1963). These two principles introduced by Bandura challenged the belief that learning occurs only after a performed behaviour is reinforced (Bandura, 1985; P. W. Corrigan, 1990). Bandura argued that reinforcement history alone was not sufficient for behaviour change and that the observation of a model was the most critical factor. However, social learning theory failed to take into account the creation of novel responses or the processes of delayed and non-reinforced imitations (Pajares, 2002). Bandura's addition of cognitive components to social learning theory ultimately led to him rename it social cognitive theory. While social learning theory emphasised behavioural learning through social rewards and punishments (reinforcements), social cognitive theory supported the notion that people's cognitive processes influence and are influenced by behavioural associations. Social cognitive theory was Bandura's (1986) response to his dissatisfaction with the principles of behaviourism and psychoanalysis, which he felt did not address the influence of cognition in motivation and largely ignored the role of the situation (Redmond, 2012). Behaviourism focuses on changes in behaviour that have direct causes existing outside the learner, while psychoanalysis is based on the observation that individuals are often unaware of the many factors that determine their emotions and behaviour (Friedman, 2006; J. B. Watson, 1913). Social cognitive theory emphasises that observational learning is not a simple imitative process and individuals are in fact the agents or managers of their behaviours (Bandura, 2001; Pajares, 2002). This theory supports the notion that behaviour is primarily self-directed, as opposed to the behaviourist thought that it is determined by environment.

In 1977, Bandura published *Self-efficacy: Toward a Unifying Theory of Behavioral Change*, in which he identified self-belief as a key element, and that was previously missing from the then current learning theories (Pajares, 2002). Bandura's article formalised the notion of perceived competence and self-belief as self-efficacy and offered a theory of how it develops and influences human behaviour (Maddux, 2012). He defined self-efficacy as "beliefs in one's capabilities to organise and execute the courses of action required to produce given attainments" (Bandura, 1997, p. 3). Situated within social cognitive theory, Bandura claimed that self-efficacy influences behaviours and environments and, in turn, is affected by them (Bandura, 1986, 1997, 2000b). Confidence in capability influences people's motivation, thought processes and emotional states regarding behaviours and behaviour change. Order of causality is the key to the utility of self-efficacy. Rather than placing outcomes which occur post-performance in a priori position, the true a priori influence is an individual's judgement of their ability to perform the task as judged before attempting the task (Fletcher, 2005). Self-beliefs affect the intention to change behaviours and the amount of effort expended to attain the goal, and persistence in continuing to strive toward the goal despite barriers and challenges. Bandura's self-efficacy theory brought together several historical trends to explain the effects of self-referent thought on psychosocial functioning (Barlow, 2013). While self-efficacy theory was not a new construct, according to Maddux (2012), what is new and important is the empirical rigour with which this idea has been examined.

Self-efficacy theory has been the subject of numerous reviews since its conception. Most of the early criticisms focused on the viability of self-efficacy as an empirical framework for understanding human behaviours; in particular that it is inherently ambiguous and lacks definition (Marzillier & Eastman, 1984), that it is descriptive of human behaviour not explanatory (C. Lee, 1992), and that it is predictive of behaviour not of cause or change (C. Lee, 1989; Ralf Schwarzer & Fuchs, 1996). More recently, the discourse has centred on identifying self-efficacy theory as a 'confounded' construct due to its problematic measurement of motivation and intention to engage in health behaviours (R. Schwarzer & McAuley, 2016; D. M. Williams & Rhodes, 2016): ratings of self-efficacy reflect motivation rather than perceived capability or intention. Altogether, these critiques of self-efficacy emphasise that it is not universally accepted as a unified theory providing a comprehensive explanation of behaviour, and that not all of its component were fully understood or explained (Biglan, 1987; Eastman & Marzillier, 1984; Smedslund, 1978). Interestingly, Smedslund (1978) argued that Bandura's theory was more about common sense observations than academic and theoretical value. Over the years, Bandura has addressed many of the critiques and provided a broad range of justifications and revisits to his theory (Bandura, 2000b, 2012; Bandura & Locke, 2003). As I further discuss in Section 2.3, critiques of the individualistic central tenet of this theory led to Bandura and others to collective efficacy theory, which recognises group behaviours, group goals and social environments. Notably, Bandura did not further expand this theory to reflect indigenous peoples' behavioural influences and associated factors.

In terms of this study, there are several limitations in the application of self-efficacy to the circumstances of indigenous peoples. Foremost, is the non-compatibility of an individually-orientated framework with the largely cultural-collective[2] lifestyles and values of indigenous peoples. In this individualistic model, a person places importance on personal goals and achievement derived from their interactions and experiences within multiple environments. I argue that this central feature of self-efficacy theory, specifically regarding individual motivations and personal achievement, conflicts with the foundations of many indigenous peoples' cultures and worldviews. While societies with individualistic cultures often focus on factors such as personal gains and individual mastery (see further below), indigenous peoples' cultures centre on more collectivist and cultural accomplishments (Orji, 2016; Triandis, 1995). This is evident within the foundations of Māori and Native American cultures, where wellbeing aspirations are generally focused on their families as a whole and not separated into individualised benefits. Studies have also shown that in determining health behaviour strategies within indigenous communities, understandings of a cultural-collective focus on relationships and connectedness is required, in that it may be difficult for individuals to change their health behaviour without the wider community implementing similar changes (A. Boulton & Gifford, 2014; Hardin, 2015). Such is the influence of culture-collective factors that they can encourage and spread behavioural change among indigenous peoples' families through avenues such as social networking. Hence, health researchers contend there are distinct differences in wellbeing behaviours in indigenous cultures whose peoples pay greater attention to, and are more heavily influenced by the opinions and behaviours of others than those in individualistic cultures (Ahn, Usher, Butz, & Bong,

[2] At this point, I merge cultural and collective to one hyphenated word (refer to my terminology explanation)

2016; Markus & Kitayama, 2010). As I explain in further detail in Section 2.4, self-efficacy theory is limited in application for indigenous peoples' circumstances primarily because it is individualistic and lacks cultural awareness.

Another limitation of this theory is that by centring on individual cognitive factors and health behaviours, it discounts or ignores the effect of structural determinants in people's everyday lives (Dutta, 2016; Hevey, Smith, & McGee, 1998). For many indigenous peoples, their current living circumstances involve considerable social disadvantages associated with historical dispossession and contemporary social structural determinants such as poverty and powerlessness (McCalman et al., 2014). Consequently, there are many aspects of indigenous peoples' physical and social environments that are imposed without their consideration or control. These impositions have an effect on health and wellbeing that are not directly addressed by individualised theoretical frameworks such as self-efficacy. For example, if a person over eats, the focus is on the individual and the habit, rather than the power of the fast food industry and other structural factors such as poverty, stress or poor housing. Indigenous health studies have shown that even when people understand the deficit impacts of unhealthy food, their eating 'behaviour' is greatly influenced by the obesogenic environments in which they live rather than their individual beliefs, self-perceptions and goals (Companion, 2013; Gittelsohn & Rowan, 2011). This has been referred to as the 'blame the victim' approach and ignores the environmental and socioeconomic circumstances of indigenous and disadvantaged communities (see further Chapter 3). Because it does not recognise and challenge the unavoidable implications of structural determinants in people's lives, self-efficacy theory is limited for practical application. Notably, I further argue in Chapter 3, that individualised theoretical frameworks often result in health programmes in the form of information or education campaigns directed at indigenous peoples' that are neither able, nor designed, to change the structural characteristics of these communities.

As I show in Section 2.3, the development of collective efficacy theory from self-efficacy theory signalled a theoretical shift to consider structural determinants. Briefly, collective efficacy theory acknowledges that factors such as poverty, stress and poor housing strongly affect the collective capacity and wellbeing of community groups (C. R. Browning & Cagney, 2002). This adaption increases its relevance to the circumstances of urban-indigenous communities who predominantly reside within lower socio-economic residential areas. Yet, limitations remain in terms of the relevance of collective efficacy for indigenous communities as it lacks recognition and understandings of indigenous-specific social determinants that impact health and wellbeing (see further Section 2.4 & Chapter Three). As mentioned in the preceding section, these include social disadvantages associated with historical dispossession and also experiences of institutional racism (Richmond & Cook, 2016). Overall, at present there is little understanding about how self-efficacy and collective efficacy theory work for different urban-indigenous groups, and whether they operate as required for these diverse contexts (Burke, Joseph, Pasick, & Barker, 2009). Specific to self-efficacy and my critique of this theory is its strong bias towards identifying health problems as individual problems rather than societal ones. This critique is explored further throughout this chapter. Nonetheless, despite the different frameworks for individual, collecitve and cutlural efficacy, the information sources that develop or enhance these beliefs are similar.

The development of efficacy beliefs begins from childhood as a child learns from manipulating their physical surroundings and through interactions with family members. Children use symbols and models to make sense of their environment which result in feedback about how capable they are in mastering various elements therein (Bandura, 1986). Bandura's theory of social or observational learning demonstrates that peoples' skills are developed through a combination of factors that provide opportunities for observations of expert 'others' engaged in practice. Observational learning can also produce new behaviours, and either increase or decrease the frequency with which a previously learned behaviour is demonstrated. Personal beliefs of efficacy are a product of four principal sources of information: mastery experiences, vicarious experiences, verbal persuasion, and physiological and affective states (Bandura, 1997, 2010). They are based on enactive experiences and interaction with the social and physical environment which provide vicarious experiences and persuasive messages related to one's competencies. Practising skills, observing models, receiving verbal encouragement or feedback, and learning to manage emotional arousal are viewed as methods to support efficacy. The social interactions that increase efficacy can be reliant on environments that facilitate ready access to experts and role models who can offer verbal encourage or feedback (see further section 2.2.3). As will be shown in Chapter Five, and in the empirical chapters of this thesis, these vicarious and indirect forms of learning are particularly important for influencing engagement in collective activities such as community gardens within marae for Māori.

The four main sources of information that influence self-efficacy (Bandura & Jourden, 1991) are also significant for collective and cultural efficacy (see further section 2.3.1 and 2.4.2). As I show in later chapters, active marae-engagement by urban Māori can enable access to all four main souces (see Chapters 7–9). Mastery experiences, the first source of efficacy, are based on personal experiences of success or failure. Prior success in achieving goals can raise mastery expectations, while repeated failures can lower them (Bandura, 1997). When a person accomplishes a successful result in tasks, it builds a robust belief in personal efficacy. People who experience success with ease may expect quick results and become easily discouraged by failure. When attributed to low effort or insurmountable barriers to achievement, failure can enhance self-efficacy. Likewise, success, when attributed to chance or help from others, can diminish self-efficacy (Warner, Schüz, Knittle, Ziegelmann, & Wurm, 2011). Mastery experiences are considered to be a leading information source for self-efficacy beliefs and one of the most effective ways of developing a strong sense of efficacy (Bandura, 1997). People can judge their capabilities according to their direct experiences and observable successes or failures when pursuing a goal. The next source of self-efficacy, vicarious experiences, refers to the effect on self-efficacy beliefs of observing others perform successfully. Self-efficacy is assisted through experiences provided by social models. Also known as modelling, this source can generate expectations of improving one's own performance by learning from observing. Although vicarious experiences are said to be less effective in increasing self-efficacy than personal experiences, seeing role models exerting effort to successfully overcome difficulties (Bandura, 1977) is valuable. As I later demonstrate, mastery and vicarious experiences are significant for indigenous peoples, who can gain cultural confidence and capacity through their interactive experiences with role models such as tribal elders and leaders.

Social persuasion, also known as verbal persuasion, is the third source and recognises verbal feedback in convincing or encouraging others to accomplish tasks. People who are verbally persuaded that they possess the capabilities to master specific tasks are likely to give greater effort and sustain their effort. Verbal encouragement from others can help people overcome self-doubt and focus on giving their best effort to the task at hand. For example, feedback from peers was deemed essential in a recent study of HIV and AIDS prevention, where men and women talked about getting tested for HIV and advised using condoms (Cain et al., 2013). The limitation of this source is in regard to creating enduring positive effects on self-efficacy because it is often easier to convince people that they are incapable of doing something and to hinder them from trying than to convince them of the opposite (Bandura, 1997). The last source of self-efficacy is the physiological and affective states that influence efficacy judgments linked to specific tasks. Emotional reactions to specific tasks, such as anxiety or stress, can lead to negative judgements of personal ability to complete tasks. People rely partly on their physiological and mood states to judge their capabilities (Bandura, 2010). Physiological and affective states have been found to hinder physical activity in older people, (L. L. Lee et al., 2012). According to Lee and colleagues (2012, p. 1695), "feeling stressed or diffident may undermine an individual's perceived ability to undertake a specific behaviour and the stressful emotional state may eventually lead to the termination of the behaviour". For indigenous peoples, affective states arising from cultural oppression and marginalisation can also negatively impact the development of cultural efficacy (see Section 2.4). In general, while efficacy beliefs are developed as a result of these main information experiences, environmental factors can have an important role in providing access to many of these experiences. Below, I further explore the influence of environment and its associated factors on efficacy beliefs. Defining environmental influences is significant because culturally-loaded places are integral to my argument about 'where' cultural efficacy can be developed.

2.2.2 Environmental influences and individual factors

A central tenet of social cognitive theory is that human behaviour operates within a framework of triadic reciprocal determinism involving interactions between personal factors, behaviours, and environmental factors (Bandura, 1977, 1997, 2010). Broadly, environmental factors comprise of situation, place, roles models and relationships. They can be internal or external. Internal factors are conditions within a specific place, and external factors are conditions surrounding a place. External environmental factors that influence the development of self-efficacy include physical space and government policies, among others. Bandura's model portrays human functioning as a dynamic system comprised of reciprocal relationships among each of the three main categories of determinants. Bandura (1989, p. 1175) argues that it is a model of emergent interactive agency:

> Persons are neither autonomous agents nor simply mechanical conveyers of animating environmental influences. Rather, they make causal contribution to their own motivation and action within a system of triadic reciprocal causation. In this model of reciprocal causation, action, cognitive, affective, and other personal factors, and environmental events all operate as interacting determinants.

A key feature of this model is that it identifies a continuous bidirectional interaction between each determinant (Bandura, 1977), and provides a framework for understanding human behaviour including why people make decisions and choose certain behaviours (see Figure 3).

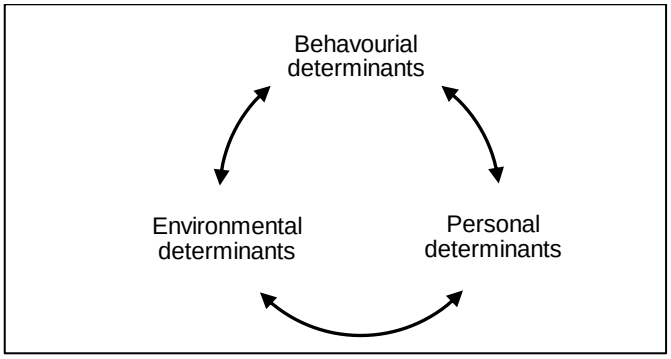


Figure 3: Triadic reciprocal determinism model (sourced from Bandura, 2012)

Within this model, the dynamics between these factors are emergent as they may influence each other at different times and in different sequences, rather than simultaneously. Yet, Bandura argues that reciprocity does not mean symmetry in the strength of bidirectional influences. For example, there are times when environmental factors may be the driving force in behaviour. Still, Bandura claims that personal factors are a predominant influence on self-efficacy and confidence. Hence, special emphasis is placed on the role of cognitive determinants of behaviour, not as secondary to environmental determinants but rather as actual causes of behaviour (Bandura, 1997). Bandura (2001, p. 10) further explains the connection between self-efficacy and behaviour change:

> Efficacy beliefs also play a key role in shaping the courses lives take by influencing the types of activities and environments people choose to get into. Any factor that influences choice behaviour can profoundly affect the direction of personal development. This is because the social influences operating in selected environments continue to promote certain competencies, values, and interests long after the decisional determinant has rendered its inaugurating effect.

This quotation, once again, highlights a more behaviourist approach which underestimates environmental effects and external control within disadvantaged and indigenous communities. Personal decisions to change life courses or activities for health may not be feasible or transferrable within social environments that fundamentally resist these changes. Nonetheless, Bandura's model emphasises how individual behaviour, cognitions and environmental factors have some influence on people's future behaviour. Still, it is important to note that the interaction and fluidity between these three factors can differ based on individual or community characteristics, the particular behaviour examined, and the specific situation in which the behaviour occurs. Bandura further suggests that his social cognitive model also recognises the influence of biological and personal factors such as age, sex, temperament, and genetic predisposition on behaviour (Bandura, 1986, 2004). Thus, this model

does have utility in understanding the complexities in causation, as highlighted in my earlier example of dietary changes for individuals and families within obesogenic and lower socioeconomic communities.

The influence of 'specific environmental factors' for indigenous peoples' efficacy beliefs are a central argument of this thesis, and thus require further clarification. In this section, I provide a brief explanation that I later expand on in further detail in upcoming sections and chapters. While environmental factors that influence health behaviours are diverse and complex, my critique centres on the applicability of Bandura's self-efficacy theory to two main environmental influences for indigenous peoples: specific physical places for holistic wellbeing and external sociocultural environmental factors. Firstly, a physical location can provide a site that people can readily access to enhance their efficacy beliefs. Depending on their requirements for self-, collective or cultural efficacy beliefs people can determine and engage in specific environments that contribute to the development of their capacity and confidence. For example, community halls constitute a physical place that people readily access for social interactions that also provide opportunities for mastery and vicarious learning experiences. Peterson (2016) and Hickman (2013) demonstrated that community centres have a role in social cohesion on neighbourhoods as venues for social interaction and networking (see further Section 2.3). These encounters are important for collective efficacy beliefs since they stimulate relationships, feelings of belonging and social contact. Other studies have shown that community centres are influential for civic engagement and co-operational problem solving (A. Kearns & Forrest, 2000). Alongside the benefits of engagement within physical sites for social interactions, there are also places that facilitate land interactions for physical benefits. Therapeutic landscapes are an important example of cultural and collective places with social, cultural and physical benefits (Bignante, 2015; Perriam, 2015). In Chapter Three, I further explore the role of therapeutic landscapes for holistic wellbeing. Overall, while the influence of physical environments is easily identifiable in Bandura's model for self- and collective efficacy, this does not extend to cultural efficacy. Thus, the role of specific indigenous settings or culturally-loaded places as vital information sources for the development of cultural efficacy benefits has not been recognised or evaluated. In Section 2.4.2, I expand on the brief explanation of culturally-loaded places from Chapter 1. Later, my empirical chapters' present practical assessments from Māori respondents of the physical factors and attributes of culturally-loaded places, as exampled in marae and their gardens.

The second environmental influence for indigenous peoples' cultural efficacy beliefs is more complex. I describe this environmental influence as the sociocultural elements of specific places. This includes places that are cognisant of and affected by external governmental forces, and also specific places of empowerment where indigenous leadership and autonomy are practiced. For example, cultural efficacy beliefs can be impeded by environmental factors such as imposed governmental policies, or enhanced by indigenous peoples' collective efforts for autonomy in health and wellbeing (see further Section 2.4). Cultural, economic, physical, social and political characteristics and determinants of indigenous communities are significant influences on how people within indigenous communities carry out their daily activities. It is in the communities within which indigenous people reside and the places they frequent regularly that there is potential to meet their cultural-collective needs and contribute to

their health and wellbeing (H. Anderson & Kowal, 2012; Brand et al., 2016). The locational context of indigenous communities also plays a role in their ability to be effective sources of information for cultural efficacy. Features of empowerment are an important aspect of indigenous communities, and culturally-loaded places can be regarded as empowered settings (see section 2.4.2) because they are places where indigenous community members can meet to make decisions relevant for the requirements and circumstances of the communities they work and live in (Beynon, 2013; George, 2012). Specific locations can also encapsulate both physical and socio-political features of empowerment.

Understanding the influence of exposure to cultural-collective environments also requires acknowledging that many indigenous sites, communities or places are often contested physical and social spaces, and that this tension also plays a role in efficacy and wellbeing. Aspects of the physical and social environment can influence indigenous peoples' mental and physical health, and may do so directly or indirectly. Inaccessible or poorly resourced culturally-loaded places or indigenous 'health settings' can also function as additional stressors for indigenous peoples who may already be overwhelmed by other personal, family, cultural and local circumstances (Brand et al., 2016; Burrage, Gone, & Momper, 2016; Hartmann, 2016). Ultimately, Bandura's emphasis on individual cognitive influences minimises the influence of sociocultural environmental factors, and instead favours individual fortitude regardless of or despite environmental circumstances. This seemingly asocial approach conflicts with the more centralised role of sociocultural environments and influences for indigenous communities. Hence, this creates an unbalanced influence within the model of triadic reciprocal determinism, and it therefore has less relevance for indigenous peoples. This point emphasises my contention of a fundamental mismatch of self-theory in providing understandings of indigenous peoples' efficacy beliefs, which, as I will later show, are developed as a direct result of sociocultural environments and experiences. These experiences also include acknowledgement and realisation of the effect of structural determinants on their lives. In the next section, I review the practical application of self-efficacy theory in health strategies. While these studies show how self-efficacy theory has been utilised in different areas of health systems, this framework is not generalisable for indigenous communities because it favours individualistic inclinations and accomplishments rather than collectivist, or indigenous cultural aspirations. Self-efficacy theory in practice reinforces individual agency for health improvement.

2.2.3 Self-efficacy theory in practice

Self-efficacy theory features predominantly in health studies because of its emphasis on health behaviour change resulting in improved wellbeing outcomes (Fernández-Ballesteros, Montenegro, Knoll, & Schwarzer, 2014; Fitzgerald et al., 2013; Schunk & Pajares, 2010). The range of health behaviour research is extensive, and includes behaviours relating to diet (Fitzgerald et al., 2013), physical activity (Ashford, Edmunds, & French, 2010), and dental hygiene (Kakudate et al., 2010). These studies have contributed to understandings of how and why individuals adopt healthy and unhealthy behaviours and how to change behaviours that affect health (Maddux, 2012). According to Bandura (2007), self-efficacy is linked to improved health because it supports self-management and

people taking control of their wellbeing. He explains further: “People have to monitor their health behaviour and the circumstances under which it occurs, set proximal goals to motivate themselves and guide their behaviour, create incentives for themselves and enlist social supports to sustain their efforts” (ibid, p. 2). This notion of self-management and control of health outcomes is a central feature of health promotion strategies (Pulvirenti, McMillan, & Lawn, 2014; Tengland, 2016). High or strong ratings of self-efficacy influence expenditure of individual effort, persistence and performance in health activities (Bandura, 1997; French, 2015). Hence, self-efficacy underpins individualised health promotion efforts that require personal perceptions of self-belief.

Personal efficacy beliefs can play a role in health and wellbeing because they can influence the types of activities and environments people choose (Bandura, 2011). The likelihood that people will adopt a valued health behaviour such as physical exercise, or change a detrimental habit such as overeating, may depend strongly on their self-beliefs. In recent studies, self-belief has shown a significant association with weight loss (L. L. Lee et al., 2012; Wingo et al., 2013). A study of obese middle-aged Japanese women found that self-efficacy was one of the most important psychological factors in tailor-made weight loss programmes (Matsuo et al., 2010). Self-belief in completing the programme and subsequent weight loss contributed to the women’s adherence to the programme. Two further self-efficacy studies explored positive health behaviour changes in relation to adhering to exercise and a balanced diet (Imayama et al., 2013; S. M. Phillips & McAuley, 2013; Shin et al., 2011). In her study of exercise adherence among coronary heart patients, D’Angelo (2014) found self-efficacy contributed to long-term engagement because patients’ confidence underpinned a determination to stay on their programmes. In another study, Lee and colleagues (2012) found that self-efficacy was an effective motivator in promoting physical activity among adolescent girls. Participants used pedometers and their results were documented in graphs as an incentive to maintaining their exercise outputs. While there were short-term behaviour changes in levels of physical activity among the girls, the authors acknowledged that it was unknown whether this behaviour would continue due to upcoming variables in the girls’ everyday lives.

Health research that pursues understandings of individual health behaviour change often incorporates Bandura’s triadic reciprocal determinism model into the design and methodology (Clark & Zimmerman, 2014; Mariño, Calache, & Morgan, 2013; Pinto & Ciccolo, 2011). This individualistic construct supports the investigation of research problems through the lens of an individual’s experiences, and the interplay of personal-cognitive, environmental and behavioural factors that affect their health habits and wellbeing. Researchers have applied this model in reviewing the influence of the perceived physical environment on physical activity (Hong, 2011; Lim, Waters, Froelicher, & Kayser-Jones, 2008; Motl et al., 2005). These studies analysed the interplay of personal, environmental and behavioural factors in the study participants as they undertook exercise programmes. Adherence to regular exercise was influenced by their environment and their self-beliefs of capability, while experiences and observations of others either challenged or reaffirmed their efforts. In Hong’s (2011) study, exercise programmes that provide a venue for intergenerational attendance were particularly effective. Observing others engaging in exercise was key to this study. Sedentary older adults were found to be more compliant and motivated to attend exercise classes when children and seniors exercised in one

group. The application of Bandura's triadic model in this study highlighted the interplay of various determinants in their health behaviours.

Self-efficacy in practice prioritises individual observational learning experiences. Breastfeeding studies provide important examples of the application of this theory (M. Y. Chan, Ip, & Choi, 2016; Nichols, Schutte, Brown, Dennis, & Price, 2009; Wu, Hu, McCoy, & Efird, 2014). As Nichols and others demonstrate in their studies, breastfeeding can be influenced by a mother's interpretation of her own experiences and confidence. First, mastery experiences involve the successful or unsuccessful attempts at breastfeeding and conditions surrounding her attempts. Then, vicarious experiences of others' breastfeeding experiences are powerful sources of information. Third, verbal appraisals from family members, friends, or health professionals can provide assessments of the mother's abilities. Finally, negative physiological arousal such as anxiety and stress relating to her ability to breastfeed may reduce self-efficacy, while self-efficacy can be enhanced through positive arousal including excitement or satisfaction with her ability to persevere and breastfeed. The preceding brief review of self-efficacy in health studies demonstrates how individuals can increase their confidence and capabilities through observational learning experiences.

Central to self-efficacy theory is individual agency which interlinks traits such as confidence, capacity, ability, esteem, and determination. Health initiatives developed within self-efficacy frameworks target and focus on the development of individual agency and related health behaviours (Hall & McAuley, 2010; Kakudate et al., 2010). Personal dental health care, for example, requires individual effort in tasks of self-care of oral hygiene (Kakudate et al., 2010). However, many of the health and behavioural goals are often more achievable by working together through interdependent effort. For example, studies have found that diabetes initiatives for specific population groups can be more effective when facilitated as a community led engagement and activity for collective wellbeing (S. B. Harris, Bhattacharyya, Dyck, Hayward, & Toth, 2013; Tipene-Leach et al., 2013). As Tipene-Leach's (2013) diabetes study demonstrated, behaviour change within families can be more achievable when programmes are open to all family members, and those who attend are encouraged to become messengers for their extended family and community members. This approach moves away from targeting individual health behaviours to incorporate a more cultural-collective approach to family wellbeing. Notably, critiques of health initiatives that solely centre on or target individuals are not new. For example, more than a decade ago, academics argued that the emphasis on personal control and personal resources has situated self-efficacy theory firmly in a Western, independent, agentic, and individualist context (Borgen, 2005; Klassen, 2004; Lindley, 2006). As Klassen (ibid, p. 206) explains: "Even though self-efficacy has been shown to be a strong predictor of performance with Western populations, less is known about how self-efficacy beliefs operate with non-Western individuals and cultural groups". Similarly, other researchers have argued that self-efficacy theory needs to be adapted to be relevant to an indigenous context, and this requires expanding the theory beyond Western social contexts that value autonomous and bounded notions of individuality (H. Anderson & Kowal, 2012).

Critically, individually targeted interventions can encounter many difficulties in practice within indigenous communities, as illustrated in Conigrave's (2012) pilot study of an Aboriginal alcohol education and brief intervention programme. The study noted that none of the 58 aboriginal participants wanted to take part in one-on-one brief interventions and empowerment and group problem solving were viewed as more viable in tackling their challenging problems. Another study which examined what it means to be a 'healthy aboriginal person' (Heil, 2006) determined that the individual emphasis evident in many health approaches was not effective for aboriginal groups. Individual approaches failed to take account of the relationships aboriginals constitute and maintain with significant others to generate meanings for themselves. In cross-cultural psychology, this is referred to as interdependent construal of 'self', and describes people who derive control from the maintenance and stability of their social relations rather than from a perception of individual agency (H. Anderson & Kowal, 2012; Kitayama, Markus, & Lieberman, 1995). As Anderson (ibid, p. 444) argues, "If we accept that indigenous cultures favour an interdependent construal of the self, then the degree to which collective structures are maintained and strengthened is relevant to indigenous conceptions of control". Hence, the individual focus of self-efficacy may be less applicable to the lifestyles and circumstances of indigenous groups.

Nonetheless, for Bandura (2000a) self-efficacy is also central to collectivistic societies because self-appraisal of personal capabilities can drive engagement in collectivistic activities and on this basis it is inappropriate to equate self-efficacy with individualism and pit it against collectivism. Although, Bandura contends that self-efficacy is not solely linked to individual agency, other academics have highlighted many of the strong individualistic features of self-efficacy. The debate over distinctions in individualism-collectivism within self-efficacy theory is ongoing (Ahn et al., 2016; Carroll, Rosson, & Zhou, 2005). To recap, I contend that the central individualistic features of self-efficacy mean this construct lacks universal applicability to the collectivistic tendencies and drivers of many indigenous groups. A number of studies have identified a preference among indigenous peoples for belonging to larger entities (tribal groups) and avoiding elements of distinctiveness within the group and in their values and lifestyles beliefs (Becker et al., 2012; Hammell, 2014; Markus & Kitayama, 2010). As Becker's (2012) research showed people within collectivist cultures develop their efficacy beliefs from those around them, whereas in an individualistic society people construct their efficacy beliefs from individualistic experiences of success and failure. Collective efficacy may therefore be a more relevant construct than self-efficacy in collectivistic contexts; where group goals and shared outcomes are of higher importance than a sense of personal identity or self-actualisation (Roos, Potgieter, & Temane, 2013). In general, strong collective proclivities remain among indigenous peoples (see further Chapter 3) that provide challenges to in-depth understandings of influences on their health behaviours and wellbeing using individualistic theoretical frameworks. A growing awareness of the shortcomings of self-efficacy in explaining group behaviours to achieve group-defined goals, led to the subsequent founding of collective efficacy theory. As I will show, although collective efficacy provides a broader group approach to health and wellbeing, it still lacks or does not prioritise cultural factors which are an integral component in the circumstances and needs of indigenous peoples (see Section 2.3.2).

2.3 Collective efficacy theory: a construct of shared beliefs in group capability

Collective efficacy theory was developed by Albert Bandura from self-efficacy theory. It is considered an essential social cognitive element of group functioning (Bandura, 1997), and a "bridging" concept between self-efficacy and social capital because of its focus on group confidence and capability (N. J. Burke et al., 2009). As Bandura (2000b, p. 75) explains, collective efficacy is a logical extension of self-efficacy because people do not live in social isolation:

> People do not live their lives in individual autonomy. Indeed, many of the outcomes they seek are achievable only through interdependent efforts. Hence, they have to work together to secure what they cannot accomplish on their own. Social cognitive theory extends the conception of human agency to collective agency. People's shared beliefs in their collective power to produce desired results are a key ingredient of collective agency.

This theory arrives at the conclusion that groups confident in their ability to succeed are more effective than groups who doubt themselves (Bandura, 1997; Goncalo, Polman, & Maslach, 2010). In the exercise of collective efficacy, people can pool their knowledge, skills, and resources to provide mutual support; they can form alliances and work together to secure what they cannot accomplish on their own (Bandura, 1997; Bandura, Caprara, Barbaranelli, Regalia, & Scabini, 2011; Lewis, 2011). Yet, there can be no automatic assumption that the group's judgment of its capabilities is accurate, as the actual skill level of the collective group may differ from its beliefs about what it can accomplish. Confidence builds over time as groups receive feedback about their performance on a task (Gibson & Earley, 2007; Tasa, Taggar, & Seijts, 2007). An important aspect of collective efficacy is that it reflects people relying on and coming together to achieve a goal, which requires social linkages and connections with each other. With a strong sense of collective efficacy, groups can set more challenging tasks, persist in the face of difficulty, and are ultimately more likely to succeed. Confidence is an emergent collective process which develops from observed behaviours and interactions between group members.

Collective efficacy has been applied to a wide range of social organisations from sports teams, to choirs and neighbourhoods (Ahern et al., 2013; M. S. Allen, Jones, & Sheffield, 2009; Earls, 2011). Other studies have used the framework to gain understandings of group behaviours and how to support the development of collective capabilities (Gibbs & Powell, 2012; T. W. Lee & Ko, 2010; Lewis, 2011). For example, collective efficacy theory has been utilised in studies of neighbourhood efficacy aimed at finding ways to resolve crime involving violence and homicide (Ahern et al., 2013; R. J. Sampson, Raudenbush, & Earls, 1997; R. L. Wickes, 2010). Sampson et al. (1997) demonstrated that collective efficacy provided an essential framework for understanding and explaining the differential ability of neighbourhoods to prevent crime and disorder. Commenting on Sampson and colleagues' contribution, Wickes (2013, p. 115) wrote : "Collective efficacy was a concept tied to normative task specific beliefs rather than social ties and it was positioned as an advance on the systemic model of community regulation, which focused more on the breakdown of ties and the

subsequent inability to exercise informal social control". In other words, collective efficacy in a neighbourhood developing collective capacity can rely on working trust, rather than personal ties. Sampson identified mutual trust and shared values as two components of social cohesion underlying the development of collective efficacy (R. J. Sampson, 2003; R. J. Sampson et al., 1997). Mutual trust is important within communities encountering crime problems as it is linked to informal social control which leads to a willingness among neighbours to intervene for each other to uphold the common good and establish neighbourhood collective efficacy.

In general, collective efficacy is about the beliefs and confidence of particular groups in choosing how and when to participate in tasks together. Accordingly, collective efficacy is not the sum of the individual members' self-efficacy, but an individual's perception of the group's performance and the efficacy of the interactions between group members (Esnard & Roques, 2014; Velasquez & LaRose, 2015). Individuals within a group can differ in age, competencies, roles, culture, and status. However, the group rationale is a shared intention and belief toward a specific mutual outcome(s) (Stajkovic et al., 2009). Yet, academics argue there is some ambiguity within collective efficacy as to whether perceptions of ability and competence represent part of the collective's shared belief structure, merely reflect individual-level beliefs, or are some combination of both (Stajkovic et al., 2009; Zaccaro, Blair, Peterson, & Zazanis, 1995). While it is accepted that collective efficacy refers to people's beliefs about the collective, it is not clear that these beliefs or values are fully shared. Nonetheless, high levels of collective efficacy have been shown in health studies to increase group confidence in implementing often complex initiatives (Karasek, Ahern, & Galea, 2012; Nichter et al., 2015). In the following sub-sections, I explore the increased recognition of environmental factors for collective efficacy development, and then present practical examples of the application of collective efficacy in health studies. While I demonstrate the necessity of conceptual frameworks that recognise collective inclinations and factors linked to wellbeing, at the end of this section I argue that collective efficacy falls short of encompassing the needs of indigenous peoples. The lack of recognition and utilisation of cultural factors in this approach is fulfilled in cultural efficacy theory (see Section 2.4).

2.3.1 Social environments and collective factors

The influence of social environments, as highlighted within Bandura's triadic model, is an important contributory factor in the development of collective efficacy and health outcomes. Collective beliefs are increased through practical experiences involving group actions and collective behavioural capabilities within social environments (Beverly & Wray, 2010; Hu, Zhang, & Luo, 2016). Group health behaviours can be learnt, imitated and developed through observational experiences within particular social contexts (Bandura, 2000a; Wagemakers, Vaandrager, Koelen, Saan, & Leeuwis, 2010). Neighbourhoods are an example of social settings that can contribute to collective efficacy by facilitating experiences of collective engagement or action for collective wellbeing. Research into neighbourhood collective efficacy has provided understandings of the influence and development of collective beliefs and actions within communities, and also how the social and physical environments of neighbourhoods affect collective health and wellbeing (Mennis, Dayanim, & Grunwald, 2013; R. Wickes et al., 2013). These studies have focused on the role and function of social and physical

neighbourhood environments in communities addressing issues prevalent within their communities (D. A. Cohen, Inagami, & Finch, 2008; Comstock et al., 2010; Zhu, 2015). Neighbourhood collective efficacy has emerged as a neighbourhood-level concept whereby community members create a sense of agency (R. J. Sampson et al., 1997) with each other and assume ownership for the state of their local community (Berezin & Lamont, 2016; R. J. Sampson & Graif, 2009; Uchida, Swatt, Solomon, & Varano, 2014). Comparisons can be made between neighbourhoods and marae due to the emphasis placed on the importance of environmental and social factors among community members in the development of collective efficacy beliefs.

Community engagement and activities with family and community members are vital sources of neighbourhood collective efficacy and wellbeing. For example, intergenerational interactions within community settings are important for youth due to the exchange of knowledge which occurs. Youth benefit from neighbourhood contexts that facilitate intergenerational interactions and additional social encounters. Indeed, close neighbours and parents of close friends can enable the development of strong ties, promoting feelings of belonging for young people beyond those cultivated within their family (Berg, Coman, & Schensul, 2009; Christopher R. Browning & Soller, 2014). Interactions between family and community members also provide important observational learning opportunities within social settings which influence individual and group behaviours. As Maimon's (2010) neighbourhood efficacy study demonstrated, strong family ties and intergenerational support were influential in improved health behaviours among Chicago youth. His study analysed the suicide reports among 990 youths to find that family attachment and support within neighbourhoods reduced the individual-level probability of suicide attempts. Other youth studies have shown that neighbourhoods represent important contextual settings where youth can participate in intergenerational experiences while mastering necessary skills and tasks to transition into adulthood (Ivert & Levander, 2014; Rankin & Quane, 2002). The importance of neighbourhood events and experiences for youth, particularly urban indigenous youth, as a means of sociocultural and community connectedness has increased with growing urbanisation and tribal fragmentation that has occurred over many decades (Big-Canoe & Richmond, 2014; Kulis, Wagaman, Tso, & Brown, 2013). In Chapter 3, I provide a more in-depth review of the current circumstances of urban indigenous youth and the benefits of facilitating collective cultural activities involving intergenerational interactions that are conducive to wellbeing.

Neighbourhood collective efficacy studies highlight the complex role of environmental influences which comprise specific area characteristics including both social and physical dimensions (Ahern & Galea, 2011; D. A. Cohen et al., 2008; Comstock et al., 2010). Regarding social dimensions, academics concur that collective efficacy within neighbourhoods also reflects structural and demographic factors which affect individual and collective behaviours and wellbeing (C. R. Browning & Cagney, 2002; Warr, Feldman, Tacticos, & Kelaher, 2009; Wen, Browning, & Cagney, 2003). Hence, collective efficacy does not exist or develop in a vacuum; it is embedded in structural contexts and associated with wider political and economic factors that stratify places of residence by key social characteristics (R. J. Sampson et al., 1997). Sampson's (2003; 1997) early work showed that neighbourhood factors including poverty and unemployment affect neighbourhood efficacy as health issues and problem behaviours can arise through formal and informal mechanisms linked to social determinants. In

general, high levels of collective efficacy beliefs are not able to influence behaviour when groups lack the resources to undertake community activities, or believe the social constraints of prejudicially structured systems will prohibit them from reaching desired outcomes (Fernandez-Ballesteros, Diez-Nicolas, Caprara, Barbaranelli, & Bandura, 2002; Pajares, Prestin, Chen, & Nabi, 2009).

Physical environments also have a significant role in collective efficacy. In contrast to the non-specific and flexible environmental influences linked to self-efficacy theory (refer Section 2.2.3), collective efficacy develops from increased engagement and reliance within social settings. As Cohen (2008) and Miles (2009) argue, physical environments have growing importance because they encompass tangible features including settings and contexts that influence people to interact with each other. Alongside physical dimensions, these places contribute to ease of social interactions, networking, and mutual trust. Shared public places – for example, parks and community halls – provide essential physical venues for events and interactions that develop and reinforce collective efficacy. Increasingly, studies have demonstrated that shared environments such as community gardens enrich neighbourhood attachment and efficacy among participants (Comstock et al., 2010; Teig et al., 2009) (see further Chapter 5). Place attachment is a beneficial outcome for the development of collective efficacy derived from the emotional bond between residents and their social and physical settings (B. B. Brown, Altman, & Werner, 2012). Although I have only briefly covered the increased significance of physical environment and collective efficacy beliefs, I contend recognition is lacking of the cultural environmental factors that may have more relevance to the development of efficacy beliefs for indigenous peoples. In the next section, I further describe the practical application of collective efficacy within health studies and then present my argument that while collective efficacy encompasses cultural elements, they are neither prioritised nor central. In order to enhance the efficacy beliefs (capacity) of indigenous peoples, the cultural dimensions of environments must be integral. Collective efficacy provides understandings of group intent and motivations, but not cultural inclinations.

2.3.2 Collective efficacy and health outcomes

Collective efficacy is connected to health outcomes through the adoption and maintenance of health activities and behaviour change by groups (Beverly & Wray, 2010; Davison, Lawson, & Coatsworth, 2012; Dlugonski, Das, & Martin, 2015). For example, collective efficacy was found to be influential on treatment adherence in Beverly and Wray's (2010) study of adults living with type 2 diabetes. The study demonstrated that participants with diabetes and their spouses were influenced by their marital relationship to support each other during the programme. The couples described their relationships as integral to their adherence to exercise programmes due to features of collective support, motivation, and responsibility. Collective empowerment was significant to health outcomes for the couples because empowered couples assume responsibility for their collective health management. In another study, Cain (2013) investigated the influence of collective efficacy within South African communities and the practical application of this theoretical framework in HIV prevention and individual HIV risk behaviours. The study findings indicate that perceptions of group capability to prevent HIV were associated with lower personal HIV risk. Increased collective efficacy among the participants resulted in decreased health risk behaviours including alcohol consumption, decreased perceptions that others

approve of HIV risk behaviours, an increase in talking about HIV prevention, and lower rates of unprotected sex. The two studies are examples of the influence of collective efficacy on health outcomes that require increased group confidence and capability to address collective health issues. Other health studies have also indicated that the higher the perceived collective efficacy, the higher the group's motivational investment in their undertaking (D. A. Cohen, Finch, Bower, & Sastry, 2006; Halbert et al., 2013; T. W. Lee & Ko, 2010). Further, the stronger the staying power of the group in the face of impediments and setbacks, then the greater their performance and accomplishments.

Collective efficacy theory takes a collective approach to health issues and has been utilised in research on community-related problems (Ahern & Galea, 2011; R. L. Wickes, 2010). This framework recognises the interwoven relationship across multi-levels (individual level, relationship level, community level, and societal level) that exist between people and their environment (Wang & Hu, 2011). Addressing community-level health issues has been the focus of recent studies of drug and alcohol abuse in residential neighbourhoods (Ahern, Galea, Hubbard, & Syme, 2009; Cunradi, 2010; Maimon & Browning, 2012). For example, Karasek's (2012) study reviewed smoking cessation factors across 59 community districts in New York City, including collective efficacy and cohesiveness within groups and their ability to act to achieve goals. This study showed that social context has a role in shaping smoking cessation and there community norms relating to smoking behaviours. In particular, the neighbourhood social environment influenced smoking habits through social norms that defined boundaries of permissible or desirable behaviours. People's normative or everyday environments were clearly implicated in shaping health behaviours and therefore must be considered as part of health intervention efforts (Karasek, 2012). This finding has relevance for indigenous peoples and culturally-loaded places that, for the most part, can be considered as accessible and everyday environments, and an influential factor in both understanding and improving health behaviours. More health studies are required that focus on the effective combination of culturally-loaded places and the utility of their cultural foundations as an indigenous approach for health behaviour change. As I will demonstrate in Section 2.4, the potential outcomes of these collective cultural attributes is the development of cultural capacity leading to the empowerment of indigenous groups in addressing their community issues.

In summary, while collective efficacy has greater applicability to the collectivist inclinations and priorities of indigenous peoples, this framework lack or undervalues the overarching role of culture as a means of influencing and reinforcing their holistic wellbeing (see further Chapters 3 & 5). I am not arguing that self- and collective efficacy theory have no application in frameworks for understanding indigenous peoples' behaviours. Rather, I argue that determining and increasing efficacy beliefs for indigenous peoples requires moving beyond the current focus on personal and group factors. Cultural factors need to be recognised and prioritised as a significant influence on indigenous peoples' behaviours and wellbeing. In the lived realities of indigenous peoples, behavioural wellbeing influences and outcomes are reflective of a mix of individual, collective and cultural factors (see further Chapter 3). As Bandura (2002) acknowledges, the everyday lives of people cannot be reduced to polarities that arbitrarily partition human agency into individual and collective forms. He argues further

that this applies to culture as well: “There are collectivists in individualistic cultures and individualists in collectivistic cultures” (p. 274). Extending this notion, Burke (2009, p. 62S) makes a salient point:

> Rather than typifying some cultures as individualist or collectivist, simple or complex, this more flexible view of culture recognizes a range of acceptable but different orientations within a given cultural group, some of which become more or less emphasized in different situations or contexts. Thus, an analysis of behaviour in social context requires an understanding of the dynamic nature of culture and the processes by which it is brought into being

Accordingly, I maintain that cultural efficacy is a more applicable framework for understanding and enhancing indigenous people’s efficacy beliefs because it centralises culture, with individual and collective factors considered as supplementary. Although indigenous cultures are diverse and dynamic social systems, cultural factors have remained a dominant feature of the everyday lives of many indigenous groups. Thus, constructs of individualism or collectivism are not generalisable to indigenous peoples’ behaviours and wellbeing. Self-efficacy and collective efficacy have been established as important predictors of individual and group performance. It is important now to extend these theories by considering how underlying cultural factors are related to efficacy beliefs within indigenous groups. In the next section, I describe and demonstrate the more culturally applicable (culture-centred) framework of cultural efficacy. In order to address the health and wellbeing needs of indigenous peoples, a comprehensive cultural approach must be undertaken that utilises a framework based on developing cultural capacity within these communities.

2.4 Cultural efficacy theory: a construct of shared beliefs in indigenous group capability

Self- and collective efficacy theory offer understandings about how beliefs and capacity are developed at individual and group levels. I have demonstrated in the preceding sections that engagement in health activities is primarily motivated by the intention that the outcomes benefit personal and collective wellbeing. Building or reinforcing individual and group efficacy provides a foundation for increased control of health and wellbeing outcomes. Yet, as I have argued previously, both frameworks fall short of understanding or prioritising the influence of the environment and of culture on indigenous peoples. Specifically, self-efficacy falls short because it is an individualistic construct with no recognition of indigenous peoples’ cultural foundations. Collective efficacy has more relevance for indigenous peoples but largely ignores important aspects of cultural foundations. While indigenous peoples’ knowledge and experiences of their culture may vary due to their lived realities, culture is a central feature of their identity and everyday lives (see further Chapter 5). Hence, cultural efficacy is an important framework because it moves beyond self- and collective theoretical approaches to centralise indigenous culture and cultural factors for improved health and wellbeing. Previous studies concur that strategies involving indigenous groups need to take a comprehensive cultural approach to wellbeing initiatives (Basu et al., 2016; S. L. Thompson, Chenhall, & Brimblecombe, 2013). Cultural

efficacy theory underpins a health approach that can capitalise on everyday accessible cultural places and the cultural resources and experiences held within (Goodkind et al., 2015; Marquina-Márquez et al., 2016; K. Wilson, 2003). The emphasis of cultural efficacy is that indigenous wellbeing can be enhanced through the multi-directional relationships between cultural, behavioural and environment factors. Thus, cultural efficacy is both an influence on, and an outcome of, indigenous peoples' collective participation in wellbeing activities.

The development of cultural efficacy within indigenous communities is supported and influenced by their specific cultural-collective environments. As indigenous health researchers have consistently demonstrated, employing a cultural or culture-centred approach to health means working from within indigenous culture and with indigenous peoples to identify and address health issues they deem crucial (Demaio et al., 2012; Dutta, 2007) (see further Chapter 3). In upcoming sections, I explore the main features of cultural efficacy theory which I argue reinforce its applicability to the circumstances of indigenous groups. I show that environmental factors are important sources and producers of cultural efficacy and, different to self- and collective efficacy, are of equal importance to cognitive and behavioural factors. The development of cultural efficacy is largely dependent on sociocultural experiences that are uniquely and comprehensively sourced from specific cultural environments. My central argument is that health promotion located within culturally-loaded places facilitates an unparalleled collective cultural approach to indigenous wellbeing. As I show in the following chapters, everyday activities like community gardening, when located on marae, are empowered and empowering environments that build cultural capacity and increase wellbeing.

2.4.1 A cultural framework for understanding indigenous behaviour factors

Cultural efficacy theory supports a comprehensive cultural approach for wellbeing because it prioritises the dynamic relationship between indigenous peoples and their sociocultural and environmental influences. Far from underestimating the role of culture or considering culture to be a barrier or an obstacle, this framework considers culture as central to wellbeing. The main supports of indigenous wellbeing are consistently identified as land, language, and culture (Biddle & Swee, 2012; H. J. Brown et al., 2012). Stronger cultural identity and attachment has also been positively linked to improved health outcomes (Dockery, 2010; Donovan et al., 2015; Usborne & Taylor, 2010). Recent studies have identified the important protective function of cultural connectedness for indigenous peoples (DeCou et al., 2013; Muriwai, Houkamau, & Sibley, 2015; Stuart & Jose, 2014). In Muriwai's (2015) study of mental health resilience among Māori, participants who solely identified as Māori displayed higher levels of cultural efficacy which acted as a buffer against distressing conditions such as stress, anxiety, and depression. Essentially, being assured and comfortable with their cultural identity and their ability to navigate their Māori world were significant protective factors for their overall wellbeing. Similarly, Mohatt's (2011) work with 284 Alaska Native Youth found that cultural connectedness acted as a protective factor against substance abuse and suicide. Connectedness referred to the recognition of the interrelationship of culture, the natural environment and welfare for self, family, and the community. This study confirmed that connectedness to culture positively affected recovery processes and wellbeing, including reasons for living and communal mastery among the

youth. For this reason, wellbeing programmes are increasingly incorporating culture and cultural activities into initiatives involving urban youth living away or dislocated from their tribal communities (Burrage et al., 2016; Priest, Mackean, Davis, Briggs, & Waters, 2012). Overall, these studies demonstrate the effective use of culture in healing and prevention strategies for indigenous peoples, and that strengthening cultural approaches from within indigenous communities can improve their health outcomes (see further Chapter 3).

Similarly to self- and collective efficacy theory, cultural efficacy is linked to developing beliefs, confidence, and capacity. However, uniquely in this framework, identification and connection within indigenous culture is central and develops from a multitude of cultural experiences, interactions, and resources (Houkamau & Sibley, 2011; Muriwai et al., 2015). Cultural efficacy is culturally-specific, as it refers to practices that indigenous peoples engage in and feel capable of performing within their groups' cultural traditions and cultural places (Briones, Tabernero, Tramontano, Caprara, & Arenas, 2009; Hagman, 2006; Sibley & Houkamau, 2013). As Houkamau (2010, 2011) has consistently demonstrated in her studies, cultural efficacy and active identity engagement contribute to increased Māori wellbeing. She defines cultural efficacy as the extent to which an individual perceives they have the personal resources required (i.e., the personal efficacy) to engage appropriately with other Māori in Māori social and cultural contexts. For Māori, the personal resources that enhance cultural efficacy are the ability to speak and understand Māori language, knowledge of cultural practices, customs and marae etiquette (meeting house etiquette), and the ability to confidently articulate their heritage. Māori respondents with high cultural efficacy felt comfortable and accepted among other Māori, and in situations which require the active expression of Māori customary knowledge and ways of doing things, including participating in Māori ceremonies, activities, and events. Houkamau's ongoing work regarding Māori cultural efficacy provides essential understandings of how increased cultural identity and knowledge has a measurable effect on Māori wellbeing.

Cultural efficacy theory extends from self- and collective efficacy and prioritises cultural capabilities rather than distinct individual or social group capabilities. That is not to say cultural and group capabilities are mutually exclusive, as they both represent collective engagement for collective wellbeing. For example, indigenous language revitalisation efforts represent 'collective cultural efficacy', where the goal is not simply improving language proficiency but the development of speaker communities (collective enterprise). Wellbeing for indigenous peoples within a cultural efficacy framework can be derived from increased cultural connectedness and the ability to draw upon and in turn provide support to others within a cultural context (Houkamau & Sibley, 2011). By actively increasing cultural efficacy through sociocultural experiences and cultural environments, indigenous groups are (re)connecting and (re)establishing their culture as a central feature of their lives and wellbeing. At the same time, while gathering together socially, they are empowering their group and its capability for addressing relevant issues and concerns prevalent in the group and community locale (see further Section 2.4.2). In this respect, I posit that cultural efficacy is not solely linked to improved connections, capabilities and capacities for indigenous groups, but also to the revitalisation and continuity of indigenous culture, language, and traditions. Indeed, indigenous peoples' cultural

awareness and reinvigoration can be regarded as necessary preconditions for cultural efficacy (see further Chapter 3).

While cultural efficacy theory provides a culturally relevant framework to determine and emphasise the necessary factors and experiences for improved indigenous wellbeing, it is not without challenges. These challenges arise when cultural connectedness is centred as a generalisable construct that produces wellbeing outcomes for all indigenous peoples. As I will demonstrate in more detail in Chapter 3, this can be problematic for several interrelated reasons. In brief, firstly, the relevance of culture within the everyday lives and circumstances of indigenous peoples is diverse and negotiable (Colquhoun & Dockery, 2012; Palmater, 2011; Wexler, Joule, Garoutte, Mazziotti, & Hopper, 2014b). Thus, culture or a culturally-centred approach is not a panacea or treatment that can be broadly applied to health services and indigenous peoples. Second, as an indigenous person or group's' cultural efficacy increases there is increased awareness of the many societal disadvantages indigenous groups face (Mitrou et al., 2014; Waterworth, 2015). As Houkamau (2011, p. 392) argues, "Increases in cultural efficacy, and resulting increases in active engagement and participation in the Māori community may bring home the fact that Māori are categorically disadvantaged as a social group". International studies have also shown that identification and increased historical knowledge within indigenous groups often entails acknowledging and personalising the historical trauma faced by many generations (Denham, 2008; Goodkind, Hess, Gorman, & Parker, 2012). In this respect, increased cultural efficacy may negatively affect indigenous wellbeing. The challenges of cultural approaches to indigenous wellbeing are explored further in the next chapter.

2.4.2 Cultural-collective environments, cultural factors and indigenous peoples' health

The role and contribution of environmental influences increases with each extension of the efficacy theories I have reviewed. Self-efficacy develops within relatively non-specific and variable environments, and collective efficacy requires social environments that facilitate group interactions. Environmental influences for both theories are reciprocal to cognitive and behavioural influences, but are not of equal strength and nor do they operate at the same time. As Bandura (1985) has demonstrated, the relative influence of each of these factors varies across people, situations, and activities. While self- and collective efficacy influence and are influenced by active engagement in a variety of settings encompassing personal and social factors, I posit that cultural efficacy is ultimately and uniquely reliant on sociocultural factors and specific environments. The reliance of cultural efficacy on specific cultural environments highlights the distinctiveness of this construct from preceding efficacy theories. Specifically, increased cultural efficacy is a direct product of the effective combination of cultural environmental influences and a multitude of cultural factors and experiences. Culturally-loaded places and the comprehensive sociocultural experiences that transpire within them are one of the most important contributing factors for cultural efficacy development (refer to Chapter 5).

Culturally-loaded places, or indigenous sociocultural settings, are venues or locations where indigenous people meet and practice aspects of their culture, providing a physical site as a source for cultural efficacy. They are meeting places for indigenous peoples to socialise, share knowledge, and witness or partake in cultural practices. They are not scattered sites of culture, for example burial sites or places where cultural ceremonies are only undertaken at specific times or events. I utilise the term culturally-loaded places to reflect a multitude of features relevant to indigenous sociocultural places that are local, accessible, and where cultural traditions are fluid and regularly practiced. The main cultural efficacy sources are located within these environments and there is a dynamic relationship between people, cultural traditions and practices. The opportunity to engage and witness indigenous group members within culturally-loaded places contributes to cultural confidence, awareness and wellbeing (Donovan et al., 2015; Schweigman, Soto, Wright, & Unger, 2011). Attending indigenous cultural activities in their community provides an opportunity for indigenous people to participate in their culture, receive feedback from other members of their cultural group and thereby increase their cultural efficacy through their personal experiences and feedback. Yet, negative role models can also reside within these environments and equally affected the development of cultural efficacy. Examples of culturally-loaded places include specific indigenous places, such as Native American and First Nations sweat lodges and healing circles, Australian Aboriginal healing centres and outstations, indigenous peoples' longhouses, and marae and wāhi rongoā in New Zealand (DeVerteuil & Wilson, 2010; Mahayuddin, Zaharuddin, Harun, & Ismail, 2017; Tapsell, 2002; E. Williams, Guenther, & Arnott, 2011). Many of these sites are therapeutic landscapes that assist in maintaining a cultural connection, whilst enabling relaxation and enjoyment through contact with the natural environment (Kingsley, Townsend, Phillips, et al., 2009).

Indigenous health researchers point out that specific indigenous sociocultural settings are vitally important as a connection to indigenous culture, a support for identity and wellbeing, and provide a connection back to ancestors (Kingsley, Townsend, Henderson-Wilson, & Bolam, 2013; M. R. Watson, 2006). As Wendt (2012a) argues, for Native Americans, the specific indigenous health settings linked to their culture are often the only domains in which they feel they belong and are understood, accepted, recognised and rejuvenated as native people. The need for indigenous people to access indigenous cultural sources for their health and wellbeing is becoming increasingly pressing due to the loss of such cultural identity factors as language, practices, values and beliefs (Cardinal, 2006; Gracey & King, 2009; Priest et al., 2012). Culturally-loaded places are more than physical or symbolic spaces in the daily lives of indigenous people; they are often deeply rooted in the foundations of culture and provide a spiritual relationship to the land (Tapsell, 2002; R. Walker, 1975; K. Wilson, 2003). Hence, these places are widely considered as places of refuge and learning, where the active expression of culture is most obvious (George, 2012; Hartmann, 2016; Wendt & Gone, 2012a). They are also host to traditional healing practices (Schweigman et al., 2011). The activities conducted on culturally-loaded places are often linked to pre-colonial practices and beliefs that are integral to indigenous cultural wellbeing and tie the people to their past and each other (H. Anderson & Kowal, 2012). For many indigenous groups, the physical and spiritual interaction with land is viewed as a means of reconnecting with ancestry and creating a sense of belonging. Providing a connection to land may both empower and promote health (Kingsley, Townsend, Phillips, et al., 2009). Culturally-loaded

places can influence the development of cultural efficacy, identity and ethnic group pride, which in broad terms may contribute to positive wellbeing outcomes for indigenous people (Houkamau & Sibley, 2011).

In New Zealand, cultural efficacy for Māori can be supported and strengthened by active engagement in marae which incorporate a wide range of sociocultural experiences (Gillies & Barnett, 2012; Houkamau & Sibley, 2011; Jansen & Jansen, 2013). Cognitive and interactive experiences with both traditional and contemporary aspects of Māori culture within marae enable observational learning interactions and the development of cultural efficacy (George, 2010; Jansen & Jansen, 2013). Marae are predominantly operated and controlled by their Māori tribal members (Gillies & Barnett, 2012). In this regard, marae support the autonomy and sovereignty of Māori, effectively acting as a counterpoint to colonisation and the ensuing consequences that have largely removed territorial autonomy for Māori tribes (Chant, 2013; R. S. Hill, 2016; Salmond, 2012). The activities that take place on marae are decided and sanctioned by the marae committee and then facilitated by marae members (George, 2010). Committee members are elected by fellow tribal members and have a mandate to act in the best interests of the marae and the families of the marae. This important feature of marae provides their associated marae families with a sense of control and empowerment regarding the activities that take place on their marae. It also serves to ensure that local Māori have a voice in aspirational marae activities when determining which are most suitable for their immediate community. The autonomous environment of marae contributes to the reinforcement of autonomy and sovereignty of Māori as individuals and groups. Studies have consistently demonstrated that improving indigenous health is inextricably linked to empowerment within indigenous communities (S. L. Berry, Crowe, Deane, Billingham, & Bhagerutty, 2012; Mundel & Chapman, 2010). Marae are central to Māori ceremonial and community life, and a symbolic expression of political, cultural, and spiritual legitimacy (Bennett, 2007; George, 2010; Tapsell, 2002). They have become one of the last bastions of Māori culture in which Māori ways of doing things continue to prevail. As Tapsell (2002, p. 142) elaborates, marae can be interpreted as “Māori-ordered, metaphysical space, embracing the fundamental kin-based values of whakapapa (genealogical ordering of the universe according to mana descent and whanaungatanga kinship) and tikanga (the lore of the ancestors maintained by senior elders)”. Broadly, culture and family are a central feature of marae where cultural foundations are valued and practised (Gillies & Barnett, 2012). Hence, marae can be defined as culturally-loaded places (see further Chapter 5).

Finally, cultural efficacy theory has important implications for indigenous health and wellbeing strategies because it underpins a health approach that incorporates and prioritises features and assets sourced primarily among indigenous group members and within their communities. Developing cultural capacity and confidence within indigenous groups is a health strategy based on empowerment in achieving collective health goals. This theory can be linked to improved health outcomes because it moves beyond current health initiatives that have centred on cultural competence or awareness programs (see further Chapter 2). Cultural efficacy is linked to cultural environments, including contexts that are a leading influence for the development of health beliefs and behavioural change. In this study, I will show that the environmental influence of marae is a comprehensive cultural-collective support that can be effectively utilised to facilitate culturally focused health programmes. Focusing on

indigenous communities and the development of cultural efficacy may be ineffective when the real problem is the dominant culture and its oppression of indigenous peoples. Hence, a much greater emphasis on the role of 'environment' as an integral component to Bandura's triadic reciprocal determinism is required. Overall, cultural efficacy has important implications for health strategies because it can provide understandings of the adoption of healthy behaviours for indigenous groups, the cessation of unhealthy behaviours, and the maintenance of behavioural changes in the face of indigenous-specific challenges and difficulties. By increasing the ability of the indigenous communities to work together to address health issues, cultural efficacy becomes a significant cultural-collective initiative for reducing the burden of preventable disease. Identifying the sources of cultural efficacy and understanding where these efficacy beliefs originate may lead to more effective initiatives for indigenous people health improvement. Hence, as I later show, community gardens located on marae provide an important practical example of an everyday health activity enhanced by the contribution of a cultural-collective environment.

2.5 Conclusion

In this chapter, I have demonstrated that cultural efficacy theory provides a relevant framework for understanding the importance of indigenous peoples' cultural foundations and environmental influences on wellbeing. This framework provides considerations of how cultural efficacy is developed within indigenous communities and that taking a cultural-collective approach can have multiple culture-centred benefits beyond individual or collectivist wellbeing gains. I argued that self-efficacy theory centres on individual constructs of self-beliefs and collective efficacy is general applicable to social groups, but not to indigenous cultural groups. While environmental influences and factors have stronger recognition as affecting behaviours within collective efficacy, in contrast to their minimal influence in self-efficacy, a cultural efficacy framework prioritises specific cultural-collective environments. In this regard, specific sociocultural environmental factors are represented as equally important to other determinants in the model of triadic reciprocal determinism. The development of cultural efficacy also provides protective factors for indigenous peoples. Although indigenous peoples have diverse living circumstances, the development of cultural efficacy provides another approach to wellbeing based on assets and resources within their communities. As I will continue to argue throughout this thesis, the development of cultural capacity for indigenous groups within culturally-loaded places provides another means for addressing specific health issues, and other challenges facing their communities. Specific indigenous sociocultural places, such as marae or longhouses, can assist in increasing cultural efficacy for indigenous people. These physical environments are important to health and wellbeing because they offer often subtle and implicit empowerment features, and so have important implications for indigenous health development.

In Chapter 3, I further develop my argument on how cultural efficacy develops within indigenous communities by highlighting the evolution of indigenous health strategies which centre on empowerment features. I identify the increasingly important role of health settings or health promoting settings in contributing to indigenous health strategies. This will include an examination of integral

requirements or factors for indigenous peoples' wellbeing and identification of specific cultural-collective environments where these preconditions are influenced and supported. Cultural-collective approaches to health are reliant on the specific features of culturally-loaded places that are not readily available within many other social settings. I argue that wellbeing initiatives endeavouring to address indigenous peoples' health needs can capitalise on their sociocultural features to provide comprehensive outcomes. My review of indigenous health strategies focuses on health initiatives and the role of health promoting settings that provide both vital resources and experiences for indigenous wellbeing. As I will show, opportunities to provide cultural-collective health approaches that not only seek to improve indigenous health but also to reinvigorate cultural continuity have important future repercussions. These cultural approaches can incorporate multiple features best sourced from within indigenous communities.

Figure 4: Ōrākei Marae 2

Ōrākei Marae gardeners' work shed and lunch room

Chapter 3 Influencing indigenous peoples' wellbeing and capacity

3.1 Introduction

In Chapter 2, I argued that cultural efficacy theory is an important framework for understanding the dynamic relationship between cultural-collective factors and indigenous sociocultural settings and their contribution to indigenous peoples' holistic wellbeing. I demonstrated that this construct is more applicable to the circumstances and requirements of indigenous peoples because it moves beyond individualistic or collective motivations for wellbeing and prioritises a combination of cultural and collective factors. In this chapter, I draw upon the cultural efficacy framework to highlight influential factors for providing effective and appropriate indigenous health promotion. I develop my argument that improved wellbeing for indigenous people can be achieved through the combination of culture-collective health initiatives and distinctive cultural foundations located within indigenous peoples' community settings. In Section 3.2, I provide a brief overview of the circumstances around indigenous health. As I will show, efforts to improve indigenous peoples' wellbeing must be based on understandings of their lived realities and the causes of poor health, which are both diverse and complex. In Section 3.2.1, I review health promotion and its ongoing evolution toward being more effective and appropriate for indigenous peoples' health needs. I note that while there has been some development, further work is needed in considering the requirements for indigenous wellbeing. Next, in Section 3.2.2, I argue that indigenous health strategies can become more effective by incorporating social and cultural factors into programmes. Programmes that recognise the role of family and culture in health behaviours, rather than individual and personal interests, have potential for subtle but comprehensive wellbeing improvements.

In Section 3.3, I focus on the environmental influence and supportive features of 'indigenous' healthcare settings. I clarify the function of these health settings for indigenous peoples and their potential contribution for wellbeing strategies. Yet, as I will demonstrate, government support in terms of funding for indigenous health services and their programmes remains limited, contributing to health inequities. In Section 3.3.1, I explore the utility of indigenous sociocultural settings as therapeutic landscapes. The provision of a physical venue and associated wellbeing programmes that facilitate (re)connectedness for indigenous people contributes to the reinvigoration and continuation of tribal links for people, land and culture. Last, in Section 3.4, I explore the empowerment features of situating health promotion within indigenous communities. Control and delivery of programmes originates and evolves according to the contextual circumstances of the community. Throughout this chapter, cultural efficacy theory provides a useful framework for emphasising the necessary influences and supports for future indigenous health strategies. Accordingly, in my next chapter I will argue that community gardens within indigenous communities exemplify the effective and appropriate application of cultural efficacy theory in practice.

3.2 Developing cultural-collective health strategies: behavioural and cognitive influences

As demonstrated in Chapter 2, health strategies based on individualistic frameworks can be incompatible with the cultural-collective inclinations of indigenous peoples. For many indigenous peoples, the primary influential factors for engaging in health activities are neither solely individually nor collectively motivated, but in fact a combination of cultural and collective factors. At this point, I acknowledge that my differentiating between cultural and collective is problematic. Many indigenous people prioritise family obligations and requirements over personal or social group benefits. In this section, I argue that indigenous health strategies that facilitate a cultural-collective approach within health promotion efforts have the potential to significantly improve indigenous wellbeing. Continuing poor health among indigenous population groups highlights the necessity of further developing health strategies beyond the predominant individualised westernised focus. Over many decades the living conditions for a majority of indigenous communities have undergone both rapid and drastic changes which have resulted in complex and diverse health needs (Big-Canoe & Richmond, 2014; Christensen, 2013; Gracey & King, 2009). Hence, health academics agree that health systems must offer a wide range of services and programmes that meet both the cultural and collective needs of indigenous peoples (Dew et al., 2016; Ziabakhsh et al., 2016). To underline the significance and urgency of further developing indigenous health approaches, I first clarify the health circumstances and requirements of indigenous peoples by reviewing the main contextual factors that have contributed to indigenous peoples' current wellbeing.

As highlighted in Chapter 1, commonality in poor health and wellbeing persists among indigenous peoples (see further I. Anderson et al., 2016; Kirmayer & Brass, 2016). Significant disparities persist between indigenous and non-indigenous peoples in chronic disease, obesity, infant morbidity, smoking and cardiovascular disease (Huffman & Galloway, 2010; Johnson et al., 2015; Stoner et al., 2015) among others. For example, in New Zealand, Theodore's recent (2015) study showed that rates of health loss for diabetes and vascular disorders, two of the leading causes of relative health inequality between Māori and non-Māori, were 2.5 times higher for Māori than non-Māori. These health disorders have contributed to lower life expectancies for Māori males and females of 73.0 and 77.1 years respectively, compared to 80.3 and 83.9 for non-Māori males and females (Ministry of Health, 2013). Similarly, Australian studies have reported a ten year gap in life expectancy between indigenous and non-indigenous Australians due to chronic diseases (Australian Indigenous Health InfoNet, 2015; N. Cohen, 2017). Indigenous health researchers agree that across countries and contexts, indigenous people face a shorter life span due to poor health and greater social disadvantage than non-indigenous peoples (A. J. Browne et al., 2016; Dew et al., 2016; Kirmayer & Brass, 2016). Kirmayer and Brass (2016) contend that the health problems of many indigenous populations can reasonably be attributed to conditions of poverty and poor infrastructure, including an absence of local resources. It is evident that specific social determinants are at play in the ongoing effects of historical, political and socioeconomic factors that underpin indigenous health and social inequalities (Mitrou et al., 2014; Newman, Baum, Javanparast, O'Rourke, & Carlon, 2015; Reading & Wien, 2009).

The fundamental cause of indigenous health inequities are in the social structural and political arrangements that are part of the enduring legacies of colonisation (see further Axelsson et al., 2016; Kirmayer & Brass, 2016; D. R. Williams & Mohammed, 2013). As Paradies (2016) and others have detailed in their studies, these colonising processes have included: displacement, removal of children, relocation, ecological destruction, massacres, genocide, and (un)intentional spread of deadly diseases, (H. J. Brown et al., 2012; K. Wilson, Rosenberg, & Abonyi, 2011). The dispossession of tribal lands and banning of indigenous languages, alongside the assimilation and eradication of social, cultural and spiritual practices, are other processes that have directly impacted indigenous peoples' cultural foundations, and consequently wellbeing (MacDonald & Steenbeek, 2015; J K. Tobias & Richmond, 2014; Walters, Beltran, Huh, & Evans-Campbell, 2011). Taken together, these practices of colonialism have resulted in 'historical trauma' which has wide-ranging effects for indigenous peoples (Heart, Chase, Elkins, & Altschul, 2011; Sarche, Tafoya, Croy, & Hill, 2017). Historical trauma including the complex nuances of disconnection and dispossession for indigenous peoples from their cultural foundations has been identified as a significant feature in creating and sustaining poor health (Herring, Spangaro, Lauw, & McNamara, 2013; Kowal & Paradies, 2010). Indigenous peoples' cultural beliefs were oppressed and outlawed by colonial powers to enable colonial expansion and monopolies over valuable resources. Traditional methods of improving collective health and healing that were both spiritually and physically curative were outlawed, disregarded or severely undermined (Gone, 2012). In New Zealand, Māori were pressured into converting to Christian patriarchal practices while their cultural experts and their healing practices were criminalised (Wirihana & Smith, 2014) (see further Chapter 5). These consequences of colonialism are ongoing, and have had a long-term deleterious effect on Māori cultural resources, customs and holistic wellbeing. Colonialism has severed many indigenous peoples from their traditional lands and lifestyles, so contributing to ill health (I. P. S. Anderson & Whyte, 2008; Walters et al., 2011). The environmental dispossession of indigenous peoples has resulted in the recent emergence of indigenous health strategies focusing on the repossession of tribal lands and land-based wellbeing activities (see further Section 3.3.2). These land-based activities include community gardens within indigenous communities, which, as I show in Chapter 4, provide multiple benefits, not only for physical wellbeing, but also sociocultural connectedness and cultural reinvigoration.

As a result of the long legacy of colonialism, indigenous peoples have experienced, and continue to experience, substantial socioeconomic disparities that have impacted their health and wellbeing (Greenwood & de Leeuw, 2012; Place, 2012). Ongoing health problems for indigenous peoples as a result of wider societal factors stemming from colonisation have been documented, including: under-education, unemployment, and low income alongside poor housing (Herring et al., 2013; Malcolm King, Smith, & Gracey, 2009; J. Reid, Taylor-Moore, & Varona, 2013). As Reid (2013, p. 5) contends, the legalised disruption of colonial polices "was worsened by socioeconomic and political marginalisation, and by racial prejudice which was often entrenched and institutionalised". These experiences of systematic racism have been evidenced in social welfare, criminal justice and health systems (Durey & Thompson, 2012; Dwyer, O'Donnell, Willis, & Kelly, 2016). Racism within health systems has generated distrust and a lack of confidence in mainstream health services and

programmes among indigenous peoples (S. C. Thompson et al., 2015; Walsh, 2014). Other studies have documented past and present experiences of indigenous exclusion, victim blaming, shaming and stereotyping as a result of racism (Dwyer et al., 2016; Iwasaki & Byrd, 2010). As a result of these experiences, many indigenous peoples show limited utilisation of, or delayed presentation to, health services, thereby increasing the burden of illness, disease and mortality. Indigenous health researchers maintain that there has been very little attention to or progress in improving any of the significant determinants of indigenous health, including environmental conditions, housing and education (Durey & Thompson, 2012; Walters et al., 2016). Davidson (2013) argues that current health strategies need to be based on understandings of the ongoing effects of colonisation, and that comprehensive engagement with indigenous communities must be at the centre of indigenous health initiatives and policy. In particular, addressing the distal determinants of racism and colonial structures can be assisted through empowering indigenous peoples' sociocultural and political sovereignty. As I will demonstrate throughout this chapter, empowerment factors are central to indigenous wellbeing, in particular autonomy in health and health programmes.

The complexity of indigenous peoples' wellbeing issues as a result of historical and contemporary factors presents health systems with a difficult task (I. P. S. Anderson & Whyte, 2008; M. Durie, 2012; Gracey & King, 2009). Alongside the everyday living conditions of indigenous peoples in rural and urban areas, the relevance of culture and cultural knowledge has become increasingly variable diverse (Gone, 2011a; Wilk & Cooke, 2015). There are varying lived realities of socioeconomic circumstances, geographic location, and, importantly, consequences of colonisation among indigenous peoples (Mitrou et al., 2014; Wilk & Cooke, 2015). Health systems must consider these diverse aspects within indigenous groups and for their wellbeing requirements, rather than assuming cultural homogeneity (Demaio et al., 2012; Hodge, Jackson, & Vaughn, 2010). Worldwide, different indigenous groups each have their own unique belief systems and understandings of wellbeing (Huffman & Galloway, 2010; Malcolm King et al., 2009). Central to future health strategies will be addressing the differing composition, needs and preferences of indigenous populations, including the wider social context of their everyday lives (DiGiacomo et al., 2011; Reilly et al., 2011). A cultural-collective approach can contribute to developing indigenous health services and health promotion that respond appropriately to the dilemmas created by this complex history and social context. In the two sections below, I highlight current health promotion efforts that have evolved to include cultural approaches, but, I suggest, require further adaption. I then explore the concept and practice of cultural-collective approaches in health strategies as a means of resolving indigenous health issues.

3.2.1 The evolution and limitations of health promotion

Health promotion has a long history, emerging as a distinct concept in the 20th century involving strategies for environmental change that reduces and eliminates health risks. The most well-known definition of health promotion was developed and articulated in the Ottawa Charter for Health Promotion (WHO, 1986, p. 1):

> Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental, and social well-being, an individual or group must be able to identify and realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living.

For health academics, the main aim of health promotion is to positively influence the determinants of health in order to improve health outcomes, including living and working conditions that affect health (Dustin, Bricker, & Schwab, 2010; Tengland, 2016). Over time health promotion has evolved due to changing patterns and theories of disease, technologies and social factors (Catford, 2011; Mittelmark, Kickbusch, Rootman, Scriven, & Tones, 2008; Tountas, 2009). Broadly, this evolution has occurred over three phases of health promotion: biomedical (pre-1970s); social (from the 1970s onwards); and ecological (from the late 1970s onwards). As argued by Baum (2014) and others, this evolution has been necessary due to the limitations of health promotion based on biomedical behavioural models for health improvement, which were neither effective nor appropriate across countries and contexts (Le Grande et al., 2017; O'Hara, Taylor, & Barnes, 2016). However, health promotion has predominantly focused on health education or behaviour change campaigns, while ignoring the social context of indigenous peoples' everyday lives (Baum & Fisher, 2014; Greenwood & de Leeuw, 2012; Pholi, Black, & Richards, 2009). As explored below, my critique of health promotion is that despite some progress from biomedical to ecological models, most programmes remain fundamentally underpinned by individualism.

Indigenous health academics have argued that one of the main features of health promotion efforts has been a focus on westernised health-related attributes and behaviours (Ayo, 2012; Mundel & Chapman, 2010; Timu-Parata, 2009). Early manifestations of these programmes were characterised by biomedical approaches that employed individualised clinical diagnosis and treatment processes. As Mundel (2010) argues, this individualised approach had westernised underpinnings that contradicted indigenous understandings of holistic health which encompass the physical, emotional, mental and spiritual wellbeing of individuals, their families and communities. Others have argued that the reliance of health systems on a medical model of health contributed to programmes incorporating 'victim blaming' and 'one-solution-for-all', in which individuals were persuaded to change behaviours with little regard for cultural influences of family and associated values (Airhihenbuwa et al., 2014; Bond et al., 2012). Smoking cessation programmes targeting indigenous peoples demonstrate some of the ongoing challenges and tensions of applying western individualised approaches. Several studies involving Aboriginal Australians have reported that changing smoking behaviours can be difficult as this activity is considered a tradition-based collective practice (Carson et al., 2012; Dawson, Cargo, Stewart, Chong, & Daniel, 2013; Power, Grealy, & Rintoul, 2009). Further to this, Bond (2012) argues that 'sharing a cigarette' is considered a socially acceptable activity that enables indigenous peoples to reaffirm, strengthen and maintain their cultural identity. In this regard, smoking is not considered as a health problem but is seen as a cultural-collective protective activity which counters oppression issues including marginalisation and racism. Other studies have shown that westernised approaches also lack understanding of the much greater challenges faced by indigenous peoples, which include

poverty, inadequate resources, high rates of smoking, and acceptance of smoking in their families and communities (DiGiacomo et al., 2011; Johnston & Thomas, 2010). Expectations of individual behavioural change can be unrealistic when everyday living circumstances contribute to and support 'unhealthy' habits. Taken together, many smoking cessation programmes have highlighted the disconnect between conventional health promotion and indigenous peoples, their living contexts and prioritisation of cultural or family obligations before treatment (see further section 3.2.2).

The lack of consideration of indigenous peoples' social contexts by health systems has been consistently identified over many years as a shortfall of biomedical approaches (Ellison-Loschmann & Pearce, 2006; Mundel & Chapman, 2010; Timu-Parata, 2009). These studies demonstrated that indigenous peoples' social contexts include socio-economic, cultural and lifestyle factors in which issues such as access to healthcare and ethnic discrimination are ongoing. Hence, it was recognised that health promotion needed to evolve to ecological models of programme delivery which consider the influence of social and environmental factors for indigenous wellbeing. Ecological strategies focus on changing governmental, organisational, community, and public policy factors which support and maintain unhealthy behaviours. As discussed in Chapter 2, adhering to governmental campaigns directed at health behaviour change is difficult when indigenous peoples' living conditions, including unemployment, poverty, and lack of education, severely undermines their ability to freely make choices for behaviour change. Critics have argued that health promotion focused on educating individuals for behaviour change cannot improve health across all population groups in isolation from other factors, such as social determinants (Hancock, 2011; McQueen & De Salazar, 2011). Netto (2010) and others see addressing deep-rooted influences linked to health behaviour as a priority, including the complex effects of social and structural factors (De Jesus, 2010; Rotheram-Borus, Swendeman, & Chovnick, 2009). These factors are complex within indigenous communities because they involve issues such as poor housing, crowding, crime, pollution, and inadequate basic services.

Since the 1980s, ecological models of health promotion have focused not only on the population at risk, but also on the environmental conditions that contribute to health and health behaviours (Richard, Gauvin, & Raine, 2011). This evolution in health promotion has been significant for indigenous peoples, due to the growing recognition that social inequalities in health have a direct effect on larger contextual determinants of health, such as socioeconomic factors and other social and cultural influences (Mundel & Chapman, 2010; Reilly et al., 2011). Health researchers have demonstrated that ecological programmes are more relevant for indigenous peoples because they centre on addressing the needs of the whole person, which includes changing social and economic conditions in order to improve holistic health (Kingsley et al., 2013; Mundel & Chapman, 2010). Alongside the increased focus on the effect of social context on health behaviours, this health promotion model also recognised the influence of culture. Examples of this approach to indigenous health can be found in breastfeeding studies where the influence of social and cultural factors is evident in the choices and actions related to mothers feeding their babies (Cidro, Zahayko, Lawrence, McGregor, & McKay, 2014; Dodgson & Struthers, 2005; Eckhardt et al., 2014). These factors include cultural or family traditions and life circumstances, such as socioeconomic levels. Notably, in Cidro's (2014) qualitative study, primarily among grandmothers in First Nations and Aboriginal communities, discussion centred on cultural

influences for breastfeeding. Cultural influences for breastfeeding were identified as important for family and cultural wellbeing in contemporary contexts, including restoring cultural childrearing skills. As Cidro noted, health programmes that recognise and promote traditional knowledge while teaching transcultural skills were viewed as an essential component in rebuilding and enhancing family skills. More importantly, as the breastfeeding programmes contributed to improved infant health, mothers were empowered to make informed decisions about childrearing.

Health promotion has evolved to provide more comprehensive and culturally relevant programmes. This has resulted in an increasing number of ecological programmes for indigenous peoples that address areas such as obesity (Willows, Hanley, & Delormier, 2012), and physical activity and nutrition (Ball, 2015; Nelson, Abbott, & Macdonald, 2010). Yet, Barnett (2011) and Durey (2012) argue that many health programmes still rely on biomedical approaches which directly and indirectly involve negative medical interactions, lack of cultural competence, and individual models and concepts of health which do not match the cultural collectivity of indigenous life. Other studies have shown that programmes also continue to be implemented in indigenous communities without local knowledge of effective or appropriate service delivery or resources (Demaio et al., 2012; Gould, Stevenson, Cadet-James, & Clough, 2016). For example, Schoen's (2010) study reported that a diabetes programme aimed at an indigenous Australian community included resources that were unsuitable for their living circumstances. Participants were provided with bumper stickers and fridge magnets with health messages regarding foot care, yet many attendees did not own either a motor vehicle or a fridge. Other health researchers maintain that without collaboration with indigenous peoples, programmes will be untested or otherwise unsuitable for their life circumstances or economic resources (J. Allen et al., 2014; Schoen et al., 2010; Snijder, Shakeshaft, Wagemakers, Stephens, & Calabria, 2015).

Ongoing connections to individualism in current health promotion efforts make them ineffective for many indigenous communities and their engagement in health activities (Baum & Fisher, 2014; Baum & M Sanders, 2011). As Tricket (2013) explains, although ecological approaches have evolved to develop community capacity, the outcomes of these programmes focus primarily on individual-level change. Hunter (2010) refers to this phenomenon as 'lifestyle drift', whereby governmental organisations commit to addressing wider social determinants or 'upstream determinants' but instead drift 'downstream' to instigate narrow lifestyle interventions and individual behavioural change. Baum (2011) and Hunter (2010) argue similarly that these approaches continue to dominate because 'medical ideology' stresses individual responsibility, and lifestyle responses do not threaten the powerful interests of governmental and transnational corporations. Hence, lifestyle drift occurs despite the ongoing efforts of health advocates, indigenous and non-indigenous, to draw attention to sociocultural factors which shape health behaviour and outcomes. Other studies have shown that many programmes introduced into indigenous communities have been adapted or culturally tailored to promote cultural models of wellbeing, yet ignore the influence of family or have expectations of individual change (Alegria et al., 2010; Castro, Barrera, & Holleran Steiker, 2010; Kirmayer, 2012). Notwithstanding, ongoing development in health promotion has occurred as a result of increasing numbers of diverse stakeholders and further understandings that health is determined by structural, physical, mental, cultural, social, and societal factors.

Indigenous health researchers concur that while health promotion has made progress over the last 40 years, fundamental issues and challenges specific to indigenous health remain (Demaio et al., 2012; Edgerly et al., 2009; Mundel & Chapman, 2010). The current health promotion discourse emphasises that future strategies require increased efforts to improve issues such as equity and empowerment within indigenous communities (Aniza & Norhayati, 2016; Kirmayer & Brass, 2016; McPhail-Bell et al., 2015). As Kirmayer (2016, p. 106) aptly explains, understanding the issues of colonisation and social determinants provides a basis from which to address indigenous peoples' holistic health needs:

> Understanding the dynamics of disempowerment or loss of control over individual and collective destinies is important for the identification of strategies for health promotion and recovery. If the ill health of Indigenous populations stems not just from exposure to historical violence and continuing deprivation due to unfair distribution of resources, but also the absence of recognition of their cultural identity and political autonomy, then solutions need to be sought not only in redistribution, but also in social, cultural, and political recognition.

This statement highlights systemic issues linked to colonial relationships of power and control (Mundel & Chapman, 2010). In sum, health researcher concur that conventional health programmes remain strongly influenced by individualistic approaches to treatment which have a long-standing history of racism and lack of cultural awareness (Baum & Fisher, 2014; Durey & Thompson, 2012; Herring et al., 2013). This has been further exacerbated by health promotion that is developed externally from indigenous communities and managed by non-indigenous peoples who fail to understand the language, culture and realities of indigenous peoples (Durey & Thompson, 2012) (see further section 3.3). These programmes often ignore the unique cultural identities, histories and socio-political contexts of indigenous peoples. To address these current health promotion issues, I contend that cultural-collective approaches that are initiated, supported and delivered within indigenous communities represent an important opportunity to improve health and wellbeing.

3.2.2 The potential of cultural-collective approaches

Despite the ongoing progress of health promotion based on ecological influences and understandings of indigenous health, I maintain further opportunities remain for developing the utility of cultural-collective approaches. To recap, this approach is based on a cultural efficacy framework, which does not prioritise individualism but rather both cultural and collective factors. As described in Chapter 2, I employ the term cultural-collective to broadly reflect the equal relationship between the cultural and collective proclivities of indigenous peoples. To be clear, cultural-collective approaches in practice are characterised by indigenous groups whose motivation for engagement are neither solely culture-based nor family driven, but are a combination of both. Notably, this approach fosters collective wellbeing outcomes and immediate and wider family over individual or personal benefits (Hardin, 2015; Kocher et al., 2017). These cultural-collective inclinations within indigenous groups often originate or are based on tribal values and practices that have remained prevalent in their everyday lives, regardless

of urban or rural contexts and circumstances. Indigenous health studies have predominantly supported programmes and services that are 'culturally appropriate' (Kendall & Barnett, 2015) or 'culture-centred' (Dutta, 2007). However, I argue that cultural-collective approaches must also feature in indigenous health promotion efforts; primarily because of the ongoing complexity of issues and circumstances for indigenous peoples, and also the capability of current health systems for adapting and employing multiple health strategies. As I show in the next section and following chapters, the health settings of programmes are a vital component for comprehensive culture-collective health strategies to make a fundamental contribution to empowering cultural capacity and increasing indigenous wellbeing.

As I review and discuss features of cultural-collective approaches, it is important to note that this is not a completely 'new' approach for indigenous health. In many respects this strategy could be viewed as the re-establishment of a more traditional cultural approach for wellbeing – but it is not. The term 'cultural-collective' conveys a flexible hybrid approach incorporating contemporary and traditional elements. Cultural knowledges and practices have developed over many years due to multiple factors resulting from the processes of colonialism, urbanisation and modernisation (Brand et al., 2016; R. S. Hill, 2010). As a result of these processes, a return to 'traditional' cultural approaches is no longer feasible or desirable for many indigenous peoples (Big-Canoe & Richmond, 2014; Reznikova, Zamaraeva, Kistova, & Pimenova, 2014). Hence, this cultural-collective approach centres on existing cultural foundations within indigenous communities that have remained integral to holistic wellbeing. This approach moves on from 'cultural competence' or 'cultural awareness' strategies that centre on improving the capacity of practitioners and health services (Kirmayer, 2012; Roz Walker et al., 2014). Cultural-collective approaches broadly encompass strategies identified as 'culture-centred', 'culturally relevant' and 'socially oriented wellbeing' (Dutta et al., 2013; Hardin, 2015). Notably, a significant feature of this approach is its emphasis on collective motivations and outcomes as a prerequisite for indigenous group engagement.

While cultural factors can be a central influence for wellbeing behaviours among indigenous peoples, I first focus on factors of collectivism and health for indigenous peoples. Although I have linked the two constructs of cultural and collective factors, there are several features of this approach that are more firmly grounded in social or family influences than culture. This does not undermine, isolate or dismiss the influence of culture, but recognises that in contemporary lifestyles cultural factors can be secondary to factors of collectivism as motivators. Family wellbeing and social connectedness can be the leading influence for engagement in health programmes, as opposed to increased knowledge of cultural traditions and values (Stuart & Jose, 2014; Waterworth, Rosenberg, Braham, Pescud, & Dimmock, 2014). For example, recent studies by Kocher (2017) and Hardin (2015) highlighted collective or family influences on the eating behaviours of Samoan community members. Hardin (2015) explained that American Samoa is a collectivist society which means decisions are undertaken jointly by the family or community group in consideration of the interests of the group. Despite the increasing westernised influences in American Samoa, family networks remain central to life and health. Thus, family is considered one of the main components of wellbeing and central to health decision making. Similarly, Kocher's (2017) study involving 18 pregnant women found that family had

a significant impact on health behaviours during pregnancy. Interestingly, both studies concluded that family can both enable and prevent improved health behaviours. Hardin (2015) spoke of the difficulty of effecting individual change within families when collective practices often countered these measures. She noted that reducing sugar intake for individual family members is difficult when one pot of tea is made for everyone, and reducing individual salt intake is not possible with one pot meals. Due to the challenges to individual change, these studies indicated that collective approaches that supported family health and change would ultimately benefit all family members.

Collective approaches for indigenous health centre on the circumstances of the whole family, and family wellbeing is often prioritised over individual or personal wellbeing (Malcolm King et al., 2009; Michael J. Kral & Idlout, 2012). In New Zealand, the number of family oriented health services and programmes has increased in response to the ongoing health inequities between Māori and non-Māori (Came, McCreanor, Doole, & Rawson, 2016; P. Reid & Robson, 2006). Health systems are adopting a distinct model of practice called 'Whānau Ora' and developed by Māori health providers, community leaders, policy makers, and Māori academics. This is a family-based service, where the emphasis is not just the nuclear family, but wider kinship networks (Te Puni Kōkiri, 2012a; Turia, 2010). As Boulton (2014) explains, at a philosophical and conceptual level, Māori understand whānau ora to mean the wellbeing of the extended family, and that wellbeing is measured or considered in its broadest and most holistic sense. As I demonstrate in Chapter 5, Whānau Ora programmes have developed as a result of the ongoing efforts of Māori to (re)gain control of their health and health services, and because a collective approach to optimal health has more relevancy for long-term outcomes. International studies are increasingly demonstrating that family-based interventions are effective cognitive behavioural strategies that with indigenous community collaboration, can address both family and community health issues (Calabria et al., 2013; Kumpfer, Magalhães, & Xie, 2017). Other studies are also showing that indigenous health strategies involving family behaviours can be more effective when the focus is on small changes within their living circumstances, and which do not involve drastic or complex health strategies (Hamerton, Mercer, Riini, McPherson, & Morrison, 2014; Hardin, 2015; McDonald, Slavin, Bailie, & Schobben, 2011).

The family wellbeing benefits of small but significant collective behaviour change are exemplified in two recent studies of eating and hygiene strategies. First, Hardin (2015) demonstrated that eating and drinking habits among American Samoan family members were influenced by shared meals. Family members ate meals together, and individual members said they ate 'whatever' was provided to avoid disrupting the family unit. This study showed that small changes could be made with purchasing and preparation choices, including cutting fat off meat and preparing means without salt. Second, MacDonald's (2011) study involving indigenous Australian families showed that conventional strategies for childhood infections largely focused on vaccination campaigns, while overlooking more practical and affordable solutions such as hand washing behaviours at home. MacDonald further commented that the simplistic intervention of hand washing has been ignored by governments due to social sensitivities and political factors. Yet, health workers indicated that hand washing can be effective despite often overwhelming issues of social disadvantage and fears of 'victim blaming' in families. Despite the multifaceted and complex social and health issues, failure to take any action in

terms of the continuing outcomes of poor child health was identified by local health workers as more damaging. As I demonstrate in Chapter 4, this study has important parallels for community gardens in that small incremental change and everyday activities resulting in collective behaviour change can be more acceptable and feasible than conventional health education campaigns for indigenous communities.

Alongside the importance of collective or social factors for indigenous wellbeing, culture remains a central influence for health promotion engagement for many indigenous peoples. Studies have broadly shown that the main preconditions for improved indigenous wellbeing include outcomes such as cultural connectedness (Mohatt et al., 2011), intergenerational knowledge exchanges (Browne-Yung, Ziersch, Baum, & Gallaher, 2013) and cultural continuity (M. D. Auger, 2016). As Airhihenbuwa (2014) and others have demonstrated, programmes that capitalise on cultural factors are valuable in terms of their longevity and applicability for indigenous peoples (Donovan et al., 2015; Fiedeldey-Van Dijk et al., 2016). Yet, other health researchers have indicated that issues remain in ensuring that effective and appropriate approaches are applied within the broad realms of health systems (Dawson et al., 2013; Geana, Greiner, Cully, Talawyma, & Daley, 2012). Nonetheless, the demand for 'new' approaches or alternative culture-based approaches is gaining strong support from indigenous researchers who have identified the reinvigoration of cultural foundations as being at the forefront of health promotion strategies involving indigenous communities (H. Anderson & Kowal, 2012; Hartmann, 2016). Cultural-collective concepts and practices in health programmes can increase their acceptance, salience, and effectiveness (Capstick, Norris, Sopoaga, & Tobata, 2009; Kendall & Barnett, 2015; Ratima, 2010). Many health studies have also demonstrated that the recognition of indigenous knowledges, concepts and practices within health programmes contributes to increased participation and improved health outcomes (Demaio et al., 2012; Lowell, Kildea, Liddle, Cox, & Paterson, 2015; Priest et al., 2012). Yet, it is important to note with regard to the diverse circumstances among indigenous peoples that cultural-collective approaches are not universally applicable and some may prefer conventional programmes. However this approach provides a non-conventional alternative to current health programmes (Payyappallimana, 2010).

While the health literature acknowledges the role of culture or cultural treatments in health promotion, many indigenous researchers caution against simplistic considerations of culture as a universally applicable 'cure' all (Bassett, Tsosie, & Nannauck, 2012; Gone, 2013; B. L. Green, 2010). This is because practice and understandings of culture among and across indigenous groups is dynamic, variable, and continually changing. As Gone (2013) explains, harnessing cultural practices for selective interventions is difficult because there is real variety among indigenous communities as to individual interest in and willingness to participate in native 'traditions'. Other health researchers have also argued that there are some aspects of culture that by westernised standards are not considered conducive for wellbeing (DePue et al., 2010; Kocher et al., 2017). For example, Kocher (2017) explained that large communal feasts are a common occurrence and an important part of cultural life for Samoan people. Furthermore, a heavier body weight represents strength and good health, and exercise is not a structured regime but a by-product of everyday activities such as hunting, fishing and gardening. Importantly, this study highlighted that attempts to effect behavioural change in Samoan

people without knowledge or consideration of both cultural obligations and collective lifestyles would more than likely fail. In this regard, researchers agree that using local knowledge and local processes can enhance the relevance of a cultural approach to health promotion (Barnett & Kendall, 2011; B. L. Green, 2010). Priority can then be given to the circumstances of specific indigenous communities and their wellbeing needs, based on understandings of their cultural efficacy. A total holistic view of indigenous health informs the design of programmes by taking a holistic approach that focuses on community strengths and resilience (M. Auger, Howell, & Gomes, 2016; Pyett, 2008). Knowledge of cultural history, values, behaviours and community context can guide the effective delivery of programmes (Gone, 2011a; Sabone, 2009). These programmes can be empowering for indigenous peoples because they draw upon the existing strength of their cultural foundations.

Gone (2011a) argues that the effectiveness of health promotion is increased when approaches are flexible and combine indigenous and western healing therapies. His study explored the incorporation of cultural practices into the therapeutic activities of a community-controlled substance abuse treatment centre (Healing Lodge) situated on a northern Algonquian Native reserve in Canada. Interviews were conducted with 19 staff and clients on the topic of therapeutic practices in substance abuse programmes. The focus of this study was the outpatient counselling programme which consisted of structured “lectures” accompanied by therapeutic activities. The activities included field trips, sponsored cultural events and participation in ceremonies. Notably, the cultural events and ceremonies included activities such as prayer, ‘‘smudging’’ (i.e., purifying oneself by burning sacred plants), talking circles, tobacco offerings, pipe ceremonies, sweat lodge rituals, fasting camps, and various other blessing rites. Full participation in the cultural practices was optional but was seen as routine by the participants, and many of whom had not previously participated in these activities prior to their time in the programme. Gone (2011a) explained that the programme benefits from a coherent and successful merge of cultural factors and western therapy culture. He further argued that “cultural hybridity is the way of the modern world, and no indigenous people should be imprisoned by a postcolonial nostalgia for a ‘‘pristine’’ pre-modern era” (p. 199). Similarly, other studies have concluded that health promotion can be enhanced by providing an integrated approach to wellbeing that utilises western and aboriginal practices (Hartmann, 2016; Wendt & Gone, 2012b). Importantly, programmes that feature cultural practices also contribute to efforts linked to cultural continuation or reinvigoration.

Recent health studies from America highlight the necessity of reconnecting and reinvigorating the cultural foundations of indigenous youth (American Indian and Alaska Native) to address the high prevalence of substance abuse and suicide (Kenyon & Hanson, 2012; Mohatt et al., 2011; Sarche et al., 2017). Much of this research focuses on the connection between detrimental behaviours and the culture loss or historical trauma experienced by indigenous youth. Significant research by Wexler (2009a, 2014a; 2009b) points to the correlation between positive cultural affiliation and engagement on one hand, and indigenous young people’s wellbeing and resilience on the other. She argues that establishing a strong cultural identity is particularly important for countering the systemic and structural experiences of discrimination, racism, and prejudice. Her studies demonstrate that cultural foundations provide a sense of grounding, self-worth, social connectedness, and purpose for indigenous youth.

These positive experiences can include traditional food harvesting with elders and role models. Fostering a strong cultural identity is reliant on positive cultural experiences and intergenerational interactions that develop cultural confidence and capacity. Conversely, other studies have shown than increased cultural connectedness or identity can negatively affect wellbeing. For example, increased awareness of historical trauma, such as persecution and oppression, can incur psychological distress (Bombay, Matheson, & Anisman, 2010; Quinn & Chaudoir, 2009; Weaver & Heartz, 1999). Bombay et al. (2010) explain that cultural identification is clearly complex and multidimensional in nature, therefore a greater emphasis on culturally appropriate interventions must involve promoting resilience among indigenous youth.

I have highlighted the potential influence of cultural-collective approaches for indigenous health promotion and wellbeing outcomes. The preconditions for indigenous wellbeing are linked to collective influences and outcomes involving social, family and cultural factors (see further Chapter 8). I have not comprehensively detailed specific health programmes or health issues for implementing this approach; rather, I maintain that this approach underpins generic programmes that address current indigenous health issues. More importantly, I believe that cultural-collective approaches are best situated within the control and settings of indigenous communities. This feature of the approach contributes to empowerment of indigenous peoples' autonomy and the development of cultural capacity. As I discuss further in Section 3.4, addressing indigenous health issues requires more than governmental support of indigenous health programmes. More significantly, the empowerment of indigenous peoples' autonomy in health must be supported. Next, I explore the environmental influence of indigenous peoples' sociocultural places and their role in increasing wellbeing and developing cultural capacity.

3.3 Utilising indigenous healthcare settings: environmental influences

In Chapter 2, I argued that specific indigenous settings are a significant contributing influence for holistic wellbeing. Utilising the attributes of these places to support cultural-collective health initiatives can contribute to improved indigenous health and help address complex health issues. As I discuss further below, a 'settings' approach complements cultural-collective programmes, as community members are empowered to create and control initiatives based on local knowledge of sociocultural context and achievable collective outcomes. At the same time, local knowledge means that members have first-hand familiarity with the limitations and constraints of their communities, including the social determinants that affect their everyday lives and the feasibility of wellbeing programmes. These places have a distinctive influence in the dynamic relationship between cultural efficacy and collective wellbeing within the triadic reciprocal determinism model. In this section, I review the concept and application of indigenous health settings for cultural-collective programmes. I argue that health promoting settings or places within indigenous communities can comprehensively support and facilitate effective programmes.

Importantly, I first provide some clarification on the interchangeable terms and composition of places I mostly identify as indigenous healthcare settings. While this term is broadly descriptive, it

encompasses various places and, in some cases, services that involve sociocultural experiences and health initiatives for indigenous peoples. As described in Chapter 1, the main 'settings' for this study are culturally-loaded places that are meeting places for indigenous people to socialise, share knowledge, and witness or partake in cultural practices. Marae and longhouses can also function as health care sites. Other indigenous healthcare settings include Australian Aboriginal community-based health centres (Alford, 2014), and many American Indian Health Service centres (Indian Health Service, 2015). Although Indian Health Services are primarily identified as clinic and hospital health services rather than specific cultural places, they provide localised health stations and on-reserve clinics within indigenous communities. The common feature of all these places and services is that they are located within indigenous communities and focus on improving indigenous health by providing culturally relevant programmes. Hence, I primarily describe these places as indigenous health care settings. Below, I commence with a more detailed discussion of health settings and then, in the following sections, I review the specific therapeutic and sociocultural experiences of these settings.

The 1986 Ottawa Charter articulated a clear new direction for health strategies which prioritised the role of 'settings' for health promotion: "Health is created and lived by people within the settings of their everyday life, where they learn, work, play and love" (p. 3). According to Dooris (2009), this acknowledgement of the role of everyday settings in which people live reflected a growing consensus within health discourse that wellbeing was not primarily the outcome of medical interventions, but a socioecological product arising from a complex interplay of social, political, economic, environmental, genetic and behavioural factors. Hence, since the Ottawa Charter's endorsement, numerous initiatives have sought to address health issues through a settings approach. These programmes, often prefixed with 'healthy' or 'health promoting', have been situated within settings that include worksites (Torp & Vinje, 2014b), churches (J M Stewart, 2015), schools (Flaschberger, 2013), and sports clubs (Kokko, Green, & Kannas, 2014). Much of the setting-related literature demonstrates this approach as empowering, holistic, equitable, flexible, and multi-strategy (Bloch et al., 2014; Dooris, 2009; Shareck, Frohlich, & Poland, 2013). Dooris (2009, p. 14) produced a major review of the settings approach which includes the following concise description:

> A settings approach will therefore involve understanding not only how contexts, facilities, services and programmes impact on wellbeing but also how health can be effectively integrated within the culture, structures, routine life and core business of settings – and how these interface with the resources, motivations and actions of the people within them.

In this regard, a settings approach has many requirements due to the varying environmental, cultural, social, and organisational features of each location. In general, taking a settings-based approach to health promotion entails considering people's lived contexts and making these factors the object of inquiry and initiatives, as well as identifying the needs and capacities of people found in these settings.

Health settings need to be supportive environments for personal and group health changes or development. As demonstrated in Chapter 2, environmental factors are not only the visible structures and services, but also sociocultural contexts. Hence, supportive environments include both physical and social factors that can protect against ill-health, and also enable people to increase their capabilities and develop independence with regard to their health (Bloch et al., 2014). Environmental considerations optimise the likelihood of success for programmes in terms of buy-in and feasibility of behaviour change. Poland (2009) explains that the co-operation and involvement of community members ensures local understandings of their implicit social norms, accountability mechanisms, and hierarchies of power. This also includes the physical and psychosocial environment, including broader socio-political and economic contexts. An understanding of context and history is required to ensure local issues are appropriately and effectively targeted (Richmond & Cook, 2016; Wood, France, Hunt, Eades, & Slack-Smith, 2008). Shareck (2013) maintains that 'rooting' interventions in the social context of settings can help address local issues, because it takes into account social structures such as race, institutional practices, and individual or cultural-collective behaviours. Ensuring the effectiveness of health promotion is not without difficulties, as local programmes require a greater capacity to manage complex and context-specific issues (Alegria et al., 2010; McQueen & Jones, 2007).

Firstly, addressing complex local health issues can be problematic for indigenous community-based health services due to a significant lack of governmental financial support and resources. Recent examples of these issues were comprehensively detailed by Katrina Alford (2014) in her report on the economic circumstances of Aboriginal community-based health services. This report highlighted the shortfalls of Australian health funding systems in regard to the requirements of indigenous Australian community members. Alford demonstrated that up to two-thirds of Aboriginal people rely on indigenous-specific health care services, yet three-quarters of all government indigenous health expenditure is on mainstream services, with nearly half of all expenditure given to hospitals. This spending contrasted with clear preferences among Aboriginal people for healthcare services based in their own culture and systems. The demand for community-controlled services has increased, however, there was a chronic shortage of these services. Alford (2014, p. 17) aptly summed up the inadequacies of the Australian government:

> Ineffective and inappropriate measures include governments perpetuating funding insecurity, lack of engagement with communities, racism, power inequalities and lack of community-embedded and controlled services that respond the most effectively to local needs and issues.

The report recommended that the government spend less indigenous-health funding on hospitals that were under-utilised by indigenous Australians, and increase funding for community health services. As Alford pointed out, the distribution of government funding ignored demographic trends and health needs, in effect contributing to inequitable health outcomes. Non-prioritisation, under-valuing and lack of support by successive governments were continuing issues for community-controlled health services. Yet, as Ghose (2014b) argues, when communities create their own solutions this can also be

problematic because it alleviates governmental responsibility. Ghose contends further that, paradoxically, when wellbeing initiatives are successful in becoming independent of government support, they may no longer be able apply for further assistance, or funding may be reduced.

Secondly, context-specific issues can also affect local health programmes and services. Issues for indigenous communities include lived experiences of structural barriers to health, such as: limited access to health care; limited affordable health services; racist health systems and practitioners; and discriminatory practices (Durey & Thompson, 2012; Reading & Wien, 2009). These experiences for indigenous peoples have contributed to current inequities in health and act as barriers to addressing health disparities. The complexity of requirements for cultural-collective health approaches within indigenous healthcare settings highlights some of main challenges to resolving the ongoing issues caused by proximal, distal and contextual determinants (Walters et al., 2016). As discussed in preceding sections, these determinants include factors such as negative community attitudes, unhealthy behaviours (directly and indirectly), low socio-economic position, and colonisation and dispossession. Utilising a settings approach can provide programmes that recognise these contextual issues and endeavour to capitalise on the local environmental attributes and supportive features to address these challenges and provide cognisant wellbeing strategies (Poland et al., 2009).

Nonetheless, previous studies have demonstrated the important role of community places in health promotion, including their contribution as everyday places for increasing the reach and effectiveness of healthcare (Newman et al., 2015; Poland et al., 2009). Health behaviour programmes delivered in everyday places such as schools or libraries may result in increased engagement and health improvement compared to hospitals or health clinics. For example, HIV prevention programmes conducted in venues where people engage in risky sexual behaviours, such as clubs or bars, may reach populations most at risk (Yamanis, Maman, Mbwambo, Earp, & Kajula, 2010). Hence, situating health programmes within relevant settings increases the likelihood of success because it offers opportunities to position practice in the relevant context. Programmes can be optimised to reflect specific contextual contingencies, target crucial factors that influence behaviour in the organisational context, and render the settings themselves more health promoting (Kokko et al., 2014; Poland & Dooris, 2010). Kokko (2014) and others argue that more effective settings approaches are based on initiatives that relate to the core business of the setting in question which shapes the goals of the programmes and incentivises the co-operation of the social group (Torp, Kokko, & Ringsberg, 2014a). The importance of recognising and utilising ‘whole’ settings features, including understanding the unique and distinctive composition of the location, has important implications in relation to the use of specific cultural environments for health promotion strategies (Bauer, 2017; Dooris & Newton, 2014).

The utility of settings for specific health issues has been demonstrated in emerging studies of churches and their local members. In Stewart’s (2015) study, African American churches in Philadelphia were the setting for a health initiative to identify the constructs most important to supporting their involvement in HIV testing, referral, and linkages to care. The churches offered an invaluable setting for this intervention as statistics show that African Americans are markedly more religious than any other racial or ethnic group, with approximately 87% of this population group

reporting a religious affiliation. This study found that working within church settings, including working with the church pastors and members, contributed to their effective use as an HIV testing site. Participants of this study indicated that the church was uniquely positioned as an institution that caters to the physical body as well as the spirit. Fear and stress about potential positive HIV results were alleviated within this setting because they could provide immediate spiritual counselling and support. Integrating health promotion within community setting is vital as programmes will be more effective and applicable when strengthened by active participation and input from the setting's inhabitants. Other studies of health-promoting settings have shown that this approach is holistic and multifaceted because it capitalises on features of the whole setting, social and cultural, to optimise collective wellbeing benefits (Dooris, 2009).

Capitalising on existing social resources requires community stakeholders participating in the design and delivery of the programme, and committed to the activity and outcomes (Doherty, Cawood, & Dooris, 2011; Torp et al., 2014a). With community engagement at multiple levels of health strategies, such as manager, facilitator, and consumer, then programmes can align or complement the core business of their community's sociocultural setting (Torp et al., 2014a). The active contribution of community members in all stages of health promotion can ensure that programmes are appropriate and relevant to the circumstances and requirements of their community as a whole. Health researchers agree that community involvement decreases the occurrence of programmes conceived and implemented by organisations unfamiliar with their settings (Edgerly et al., 2009; Snijder et al., 2015; Ziabakhsh et al., 2016). These studies demonstrate that health campaigns can encounter difficulties in application within indigenous communities when they are viewed as imposed by 'outsiders' and non-responsive to local community needs. As Waterworth (2015) and McPhail (2015) explain 'outsider' impositions involve non-indigenous health systems determining a community's health 'problems', and then providing fixed solutions or advice while remaining unfamiliar with their socioeconomic living circumstances. In the past, these experiences have led to indigenous groups distrusting health representatives as outsiders and resenting being told how to live their lives or being criticised for not living in a certain manner. Further to this, McPhail (2015) argues that these interventions often reinforce the power and privilege of the state. As she explains, "Health promotion practice does not then just convey advice for making healthier choices; it also symbolises a deeper fundamental message about colonial relationships of power and control and the presumed capabilities, or rather deficiencies, of Indigenous people" (p. 196). Hence, health academics maintain that the combination of outsider and conventional solutions have limited success within indigenous communities; instead, they have increased health inequalities and stigmatisation because their rhetoric amplifies perceived 'failures' (Durey & Thompson, 2012; Goldberg, 2012; Laliberté, Haswell-Elkins, & Reilly, 2009). Next, I review the role of indigenous healthcare settings as therapeutic landscapes (Gesler, 1992); they are places characterised not only by the built and natural environment, but also by how people interact with each other and the place.

3.3.1 Experiences of therapeutic landscapes

The physical site of indigenous healthcare settings for health promotion can provide important motivational factors for stakeholders, including the distinct opportunity to engage in sociocultural experiences and land-based activities that are linked to therapeutic landscapes. As Gesler (1992, 2009) and Williams (2010) explain, therapeutic landscapes are places that encompass both physical and psychological elements with enduring reputations for achieving holistic health and healing. These landscapes highlight the integral relationship between people and place in maintaining physical, emotional, mental, and spiritual wellbeing. Therapeutic landscapes can be vital supports for the construction and maintenance of identity, by acting as a location of social networks and providing settings for therapeutic activities (Milligan, Payne, Bingley, & Cockshott, 2015). These places encompass physical and emotional health benefits, alongside relational, symbolic, spiritual and healing benefits (Conradson, 2005; Liamputtong & Suwankhong, 2015; Masuda & Crabtree, 2010). Studies of therapeutic landscapes have described homes, libraries and community gardens as examples of everyday places with healing qualities (Brewster, 2014; Pitt, 2014). Gesler (2009) has written extensively about therapeutic landscapes, describing them as natural settings where a sense of place and symbolic significance interact to create a restorative atmosphere. Everyday places can promote health by conferring a sense of identity to local members, and an increased sense of security when surrounded by people with similar identities or interests. Health researchers have shown that people who socialise in the same landscape may also cultivate social cohesion (Veen, Bock, Van den Berg, Visser, & Wiskerke, 2016). Social cohesion can positively influence health by fostering the mutual exchange of resources and knowledge and promoting collective or cultural efficacy, which is the extent to which people believe in their ability to act cooperatively to solve their problems (Mennis et al., 2013; R. L. Wickes, 2010).

Notably, therapeutic landscapes may not be consistently health-promoting for all community members. The literature shows that landscapes may lead to poor health through physical features such as inadequate housing and pollution, or social features such as neighbourhood mistrust and marginalised social groups (Rose, 2012; R. Sampson & Gifford, 2010; A. M. Williams, 2010). These negative features can also involve situations specific to that environment, such as a lack of access to external resources which can increase the adoption of health risk behaviours (R. Sampson & Gifford, 2010). Other studies have shown that many indigenous communities not only have poorly resourced therapeutic landscapes, but also limited access (DeVerteuil & Wilson, 2010; J K. Tobias & Richmond, 2014). For example, DeVerteuil (2010) explains that colonisation has resulted in the creation of isolated reserves for Canada's indigenous peoples, and high levels of segregation in most cities, both of which have contributed to a host of persistent social, economic and health inequalities. Thus indigenous therapeutic landscapes can be equally capable of healing or inducing stress due to the proximal, distal and contextual determinants identified earlier in this chapter. As I will discuss further in Chapter 5, indigenous settings such as marae also encompass this duality, in that they can be healing places of cultural knowledge which counters colonialism, and also hurtful based on experiences of negative engagement including increased awareness of marginalisation. As Love (2012) argues, while healing or health enhancing places are the main tenet of therapeutic landscapes, it is problematic to assume that these places produce entirely positive effects given the places are complex and engender

multiple effects in relation to human health and wellbeing. Gesler (2009) elaborates that environmental features considered therapeutic for one person may not be for others. Hence, there are no definitive criteria for therapeutic places as nowhere is intrinsically healing (R. Kearns & Collins, 2009; A. M. Williams, 2010). Nonetheless, therapeutic landscapes can provide places of wellbeing experiences for indigenous peoples where they socially connect to their cultural identity and (re)establish land relationships.

Studies of healing landscapes have been extended in the significant development of indigenous therapeutic landscapes (K. Wilson, 2003) and, recently, urban-indigenous therapeutic landscapes (Wendt & Gone, 2012a). Recognising the importance of social and cultural connectedness for urban indigenous peoples' wellbeing, Wendt and Gone (2012a) expanded this concept to urban-indigenous therapeutic landscapes. As they explain, culture is an important contextual aspect and "although therapeutic landscapes literature has focused primarily on Western contexts, the unique intersection of culture, place and health is especially salient with reference to indigenous peoples" (2012a, p. 1026). The need for urban indigenous peoples to be able to access indigenous therapeutic landscapes for their health and wellbeing is becoming increasingly important due to the loss of such cultural identity factors as language, practices, values and beliefs (Cardinal, 2006; Malcolm King et al., 2009; Priest et al., 2012). In Wendt and Gone's (2012a) study of urban-indigenous therapeutic landscapes, Indian Health centres are highlighted as an important example of the expanding and vital role of culture-based health settings in urban contexts. This study provides insights into the unique confluence of indigeneity and urbanisation through the exploration of the context of urban health services in the midwestern United States. The authors undertook qualitative interviews with 17 adults who self-identified as American Indian and resided in Indian Health service areas. During the interviews, the respondents described Indian Health positively as a vital place to be among other American Indians and connect with culture, and also a home-like place where they felt welcome and comfortable and healthcare is relational and hospitable.

Challenges and tensions for the centres were also described, and included balancing competing narratives about native identity, alongside tribal concerns and servicing rapidly changing diverse communities with associated ills of alienation and fragmentation. The respondents also indicated that there were issues connected to providing professionalised health services amidst concerns about imitating or becoming a ''whitewashed'' corporate entity. The issues described by the study participants accentuate the difficulties of providing comprehensive programmes for urban indigenous peoples, who often have vastly differing wellbeing needs due to a wide range experiences as a result of cultural upbringing, historical trauma and barriers of access to health. At the same time, it is clear from this study that one of the most important features of urban Indian Health Services is the cultural focus and prioritising of cultural events and ceremonies that serve as a foundation for wellbeing. Wendt and Gone (2012a, p. 1032) summarise the function of these urban centres:

> Indian Health is a place – perhaps the only place – where one, ideally, belongs and is understood, accepted, recognized, and rejuvenated as a Native person. Importantly, this sense of belonging involves interpersonal networks of intimacy, familiarity, and

> shared identity, which in an urban setting likely requires the community's embrace or at least tolerance of a pan- or multi-tribal identity and culture.

The concepts and benefits of these places, as described by Wendt and Gone, have many similarities to the role of marae for Māori. In Chapter 5, I explore further the role of marae in Māori wellbeing, and align the qualities of urban marae to urban-indigenous therapeutic landscapes. Multiple holistic and land-based benefits have been identified for marae, including social, cultural, and economic outcomes complemented by the relaxation and enjoyment enabled through contact with the natural environment (P. King et al., 2015; Kingsley, Townsend, Phillips, et al., 2009). Next, I discuss the specific sociocultural features of indigenous healthcare settings, in particular their cultural foundations which represent a complex intersection of indigenous culture, social, identity, and health factors. More importantly, that they are autonomous indigenous places that can comprehensively support cultural-collective health programmes.

3.3.2 Sociocultural features of health settings

As described by Wendt and Gone (2012a), the sociocultural features of indigenous healthcare settings have an important function in ensuring the provision of a physical site for (re)connectedness of indigenous people to their culture, land, and peoples (D. L. Hill, 2006; P. King et al., 2015; Wendt & Gone, 2012a). Studies have demonstrated that indigenous peoples' health can be protected and improved through initiatives aimed at re-establishing ties with their traditional land (Kingsley, Townsend, Phillips, et al., 2009; Kirmayer, Simpson, & Cargo, 2003; Wexler et al., 2014b). These researchers found that spending more time on the land amongst other tribal members measurably improved mental wellbeing. For urban indigenous people, some of whom are fragmented or dispossessed of their tribal land, the opportunity to connect socially and physically to new culture-based sites can be an important cultural healing and wellbeing experience. The physical venue of health programmes can also present an opportunity to establish links to new land and pan-tribal relationships (Wendt & Gone, 2012a). As Tobias (2015, p. 125) succinctly explains, indigenous health and wellbeing is intrinsically linked to past and present relationships to land:

> The traditional lands and territories of Indigenous peoples have historically provided the daily nourishment, sustenance and medicines necessary for Indigenous peoples, and they have also been places where local culture, knowledge, norms, and values are shared and practiced. Maintenance of strong connections to traditional lands has been shown to result in increased self-esteem, cultural pride and overall improved physical health

Similarly, other researchers have demonstrated that land relationships are a vitally important connection for indigenous peoples' cultural foundations and support identity and belonging through intergenerational linkages (H. L. Berry et al., 2010; Kingsley, Townsend, Phillips, et al., 2009; M. R. Watson, 2006). Belonging to a group is important to an individual's self-concept and social behaviours, and the friendships and close family relationships found in groups offer support and are a major

contributor to wellbeing (Brannan, Biswas-Diener, Mohr, Mortazavi, & Stein, 2013). Connections can be formed between people and places, creating a sense of place comprised of emotional bonds, values, meanings and symbols, and an awareness of the cultural, spiritual and historical context (Foote & Azaryahu, 2009; Lengen & Kistemann, 2012). Ancestral connections through family, combined with access to traditional land and bound together by the ancestral language are key factors in the formation of cultural identity which promotes collective and individual wellbeing for healthy development in a culturally appropriate manner (H. J. Brown et al., 2012; A. Durie, 1997). Hence, when indigenous peoples (re)affirm their relationship and connections with land, they are also affirming their sense of identity as indigenous peoples.

As mentioned in the preceding section, being isolated from cultural lands has been demonstrated to negatively impact indigenous health (Malcolm King et al., 2009). In this regard, health programmes within sociocultural settings can increase and develop cultural connectedness between land and peoples. Recent doctoral research by Redvers (2016), involving 11 land-based healing practitioners from the Northwest Territories, Yukon, and Nunavut indigenous communities, identified comprehensive health and wellbeing benefits as a result of land-based programmes. This study demonstrated that holistic benefits can be derived from land-based practice, including cultural revitalisation, culturally relevant nutrition, and language transmission. Interestingly, Redvers noted 'pure joy' as an interactive land relationship outcome. Enhanced learning, community building, and environmental stewardship were identified as broader benefits. Redvers' concluding argument reiterated the significance of land and wellbeing: "Land-based connection and relationship can benefit a number of interdisciplinary areas, since the underlying trauma is 'disconnection', no matter the field you are addressing it from" (p. 152). Countering the effects of disconnection and dispossession as a result of colonisation and urbanisation is a resounding theme within literature that highlights the supportive role of land for indigenous peoples' wellbeing (Browne-Yung et al., 2013; Cidro et al., 2015).

Tobias (2015) also explored the processes and practices of environmental repossession among indigenous groups, highlighting similar land connection findings to those identified by Redvers. He reported that the direct and indirect processes of environmental dispossession and disconnection have eroded the health sustaining connection between the indigenous Anishinaabe peoples and their traditional lands. Discussions among his Anishinaabe Elders participant group emphasised an increasing need to develop strategies for practising environmental repossession and preserving cultural foundations including indigenous knowledge, for indigenous youth in particular. The elders stressed that wellbeing programmes need to focus on increasing opportunities for intergenerational connections, both in social settings and out on the land. Recommendations from the elders included re-establishing the relationship between elders and youth by increasing time spent together on traditional lands. The findings from Tobias's study have been highlighted in other indigenous studies as critical goals for health programmes within indigenous settings (J. Allen et al., 2014; H. Anderson & Kowal, 2012). As I will show in my next chapter, experiences such as intergenerational exchanges as a direct result of cultural-collective health approaches are important, not only to indigenous wellbeing, but also to cultural continuity.

Capitalising on the sociocultural features of indigenous healthcare settings can include cultural events for wellbeing activities. For example, cultural events such as pow-wows, potlatches and sweat lodges are integral community social gatherings that promote traditional activities and celebrate tribal customs, and also contribute to intergenerational and cultural connectedness (Schiff & Moore, 2006; Schweigman et al., 2011). More importantly, these events include opportunities for people to interact and receive feedback from other indigenous group members with varying levels of expertise and knowledge (Kulis et al., 2013). As Hartmann (2012) demonstrated in his study, engagement with tribal elders is crucial because as 'culture keepers' they have an integral role in cultural knowledge transmission of distinctively indigenous worldviews and traditional practices. Further, cultural peers and role models can produce a direct influence on a newcomer's success through the modelling of attitudes and beliefs. Indigenous elders and intergenerational experiences are a vital source of support for people seeking to increase their cultural efficacy (Big-Canoe & Richmond, 2014; Burrage et al., 2016). This is particularly important for indigenous youth living in urban centres who often have limited access to cultural elders and places where their culture is active and practised. Essentially, these indigenous settings provide a physical venue that can influence the development of indigenous health and health behaviours that is unique from general public areas and meeting places. These places also contribute to indigenous empowerment as they encompass features of localised autonomy, as I demonstrate in the next section.

3.4 Empowering indigenous health autonomy

In the preceding sections, I have argued that indigenous health promotion can be more applicable and effective when based on an in-depth, yet flexible, culture-collective approach that recognises local context while capitalising on distinct features of cultural foundations and sociocultural settings. Applying a cultural efficacy framework, I now argue that indigenous healthcare settings and associated sociocultural factors contribute to the empowerment of indigenous peoples to take control of their health and health services. The necessity of indigenous empowerment features strongly in indigenous health discourse, amidst increasing concerns about continued poor health (S. L. Berry et al., 2012; Haswell, Fitzpatrick, & Jackson Pulver, 2011; Whiteside, Tsey, & Earles, 2011). While public health approaches typically emphasise promoting positive health practices and reducing health risks, there is a growing body of literature that argues for a stronger focus on empowerment and right of indigenous peoples to take control of their own health (Laliberté et al., 2009; Tengland, 2016). As Laliberté et al. (ibid.) explains traditional problem-oriented interventions often exacerbate indigenous health issues by victim blaming, whereas community empowerment is a strengths-based approach that is congruent with indigenous peoples. Situating health programmes within the control of indigenous communities is more likely to build cultural capacity due to their involvement in making decisions about the outcomes and suitability of resources. This also encourages community ownership of health promotion activities and the involvement of local people ensures programmes receive local endorsement and support. Later, in Chapter 5, I show that marae are autonomous environments for Māori, thus they have a distinctive role as an empowering place for Māori to address their own health issues.

Studies have demonstrated that successful health promotion for indigenous people is characterised by a high level of indigenous community engagement, effective communication at all levels and built on local knowledge about what works and what is likely to be acceptable (Demaio et al., 2012; Liaw et al., 2011; Tipene-Leach et al., 2013). As Boulton (2011, p. 37) explains, "Programmes which demonstrate a capacity to adapt to a community's contemporary realities, are responsive to changing environments, and enable community control, will remain relevant and sustainable in spite of vagaries in funding and changes in the political landscape". Developing local capacity through motivation, resource provision and support enable indigenous communities to facilitate long-term community ownership of health issues (Barnett & Kendall, 2011; Hamerton et al., 2014; Tse, Laverack, Nayar, & Foroughian, 2011). For example, in Barnett's study involving 39 members of three Queensland Murri communities (rural, regional and urban), health programmes that incorporated and developed local leadership were considered by the participants to be more responsive to local issues. Local leadership also ensured that cultural traditions and knowledge were successfully incorporated into their programmes, which utilised accepted forms of cultural communication. Barnett argued that these features associated with local ownership and leadership fostered longevity and acceptance of health programmes among the participants.

Health academics concur that empowerment of indigenous communities contributes significantly to increased cultural-collective capacities and the ability to identify and solve health issues according to their own priorities (Demaio et al., 2012; Mittelmark et al., 2008). Collective or community empowerment enables a social movement in which members come together to develop internal cohesion, and then mobilise their power and resources to meet their health and wellbeing rights and issues. Empowerment cannot be given to people, but health programmes can help create situations where empowerment is likely, such as by helping people build their confidence and capabilities. As Laliberté and colleagues (2009) further explain, "Empowerment is not about having power over others; rather, it is about power with others to lead healthy, meaningful lives. Knowing more about how this is achieved can ensure the efficient and responsive implementation of truly empowering programmes and interventions" (p. 37). Laverack (2001) elaborates that community empowerment and health promotion is more than targeted programmes; it is about the organisation and mobilisation of communities to achieve the social and political changes necessary to redress their powerlessness. In this regard, community empowerment is complex and multidimensional due to the varying needs, circumstances and conditions of the setting and its inhabitants. Yet, Labonte (1989) and others advise the true complexity of community empowerment is that it is difficult to define and often romanticised or illusory (Braunack-Mayer & Louise, 2008; Ferreira & Castiel, 2009). These authors query how and when the transfer of power (top-down) actually occurs, and, if it does, do communities have the capacity and ability to act upon agreed community initiatives.

While studies of indigenous healthcare settings and community programmes that feature aspects of collective or community empowerment are limited, Australia has some important examples from the development of community-controlled health services. These examples of indigenous community-led health programmes can be found in the work of Aboriginal Community Controlled Health Services

(ACCHS). By definition, these health centres are not government run but community controlled. Established in 1971, ACCHS are regarded as the practical expression of Aboriginal self-determination in Aboriginal health (Bell et al., 2000; S. C. Thompson et al., 2015). Researchers emphasise that these health centres are distinct because they provide culturally appropriate, autonomous primary health services, addressing not just individual physical health, but the social, emotional, and cultural wellbeing of a community (Baba, Brolan, & Hill, 2014; Bell et al., 2000; Tsey et al., 2010). There are now over 150 health centres operating across Australia, which are managed by their local indigenous communities (www.naccho.org.au). A recent study by Baba et al. (2014) provided important insights from Aboriginal and Torres Strait Islander clients, highlighting differences between community and government controlled Aboriginal health centres. Among the 21 participants of the study there was a general consensus of discomfort with mainstream health services which resulted in their delayed access of these services. The three main discomfort factors identified were: the services' failure to acknowledge indigenous concepts of health, discrimination from health staff and other clients, and the participants' fear of medical services. The study reveals that racism, historical and current, continue to restrict the improvement of indigenous health in Australia. However, the existence and rise of culturally safe and comprehensive services within ACCHS are actively countering these negative impacts by providing holistic and locally relevant health services. These community controlled services focus on factors such as community empowerment, and preventative and supportive healthcare which challenge the downstream effects of inequality and racism (Baba et al., 2014).

Over the years ACCHS has hosted a wide variety of health programmes targeting a range of health issues including child health (Williamson et al., 2010), maternal care (Oliver, Wood, Frawley, Almond, & Larkins, 2015), chronic diseases (Panaretto, Wenitong, Button, & Ring, 2014; Jessica M Stewart, Sanon-Fisher, Eades, & Fitzgerald, 2012) and smoking cessation programmes (Sarin, Hunt, Ivers, & Smyth, 2015). Much of the literature evaluating the programmes concurs that utilising the centres was beneficial and they provided an invaluable location to encourage aboriginal participation (Black et al., 2013; Marley et al., 2014). The majority of these studies also indicate the importance of providing a culturally safe environment that has shown success in delivering interventions in other healthcare areas. While many of these studies outline the application and outcomes of their programmes, I note that very few involved community collaboration features with ACCHS and even fewer identified the cultural tailoring of programmes for their targeted community. One exception was Calabria's (2014) alcohol intervention study that specified collaborative processes in a family targeted intervention. She noted that their baseline programme was adapted after consultation with location staff and surveys with local clients querying methodologies for better service delivery and practice. At the completion of the study, Calabria concluded there is a need for further tailoring of specific delivery procedures. Altogether, these studies indicated successful outcomes for Aboriginal and Torres Islander peoples and that health services engagement was improved due to the centres. Yet, these selected studies highlight a gap for research that identifies and comprehensively evaluates a culture-based approach within indigenous community settings.

In summary, addressing the problems of indigenous health requires more than acknowledging different sociocultural contexts and incorporating cultural-collective approaches into programmes; it is

about empowering indigenous peoples' health autonomy (N. S. Berry, Murphy, & Coser, 2014; Hamerton et al., 2014; Laliberté et al., 2009). As Boulton (2011) argues, all community stakeholders including local councils, the social services sector and tribal groups must take responsibility for creating a healthy environment. Community members can also contribute knowledge of local context to assist in assessment of the variable contextual, economic, cultural, and political landscapes of indigenous communities (Catford, 2009; Laverack & Keshavarz Mohammadi, 2011). Hence, comprehensive engagement in health promotion can contribute to increased cultural relevance and appropriateness of health services. This engagement can directly and indirectly contribute to the development of indigenous capacity and strengthen community ownership. Yet, as discussed in the preceding section, local decision making and health service provision can be largely ineffective if the community has limited control over or access to governmental economic resources. Indigenous peoples have experienced comprehensive impacts to their health and wellbeing through diverse processes and experiences that have included epidemics of infectious disease, colonisation, urban relocation, separation from family, and undermining of social, political and economic foundations. This history has had complex effects on the structure of indigenous communities, individual and collective identity, and holistic health. Indigenous autonomy in health must therefore be a priority for future health strategies.

3.5 Conclusion

In this chapter I have developed my argument that improved wellbeing for indigenous people can be achieved through the combination of cultural-collective health initiatives and indigenous healthcare settings. Over many years, and as a result of the legacy of colonisation, indigenous peoples have experienced and continue to experience substantial disparities that have impacted their health and wellbeing. Historical trauma including the complex repercussions of dispossession and disempowerment from their cultural and health foundations has been a significant factor in health inequities for indigenous people. Addressing these complex issues presents health systems with a difficult task given varying lived realities of socioeconomic circumstances, structural issues, cultural understandings and geographic location. Past health promotion efforts have predominantly focused on health education or behaviour change campaigns while ignoring these social contextual circumstances of indigenous peoples' everyday lives. Notably, many strategies have remained underpinned by features of individualism, which has long-standing associations with racism and lack of cultural awareness, resulting in programmes that are ineffective for the culture-collective proclivities of many indigenous peoples. Recent health promotion discourse has emphasised that future programmes must address and improve issues such as equity and empowerment within indigenous communities. In this regard, cultural-collective health strategies that are initiated, supported and delivered within indigenous communities represent an important opportunity to not only improve indigenous wellbeing, but empower cultural capacity.

Based on cultural efficacy theory, cultural-collective health initiatives prioritise cultural and collective factors rather than individualism. Family are considered central to wellbeing, and a major influence in

health decision making. Hence, health programmes that support families to make wellbeing changes, albeit small, within their everyday living circumstances can contribute to wider health outcomes. Further, the facilitation of experiences of cultural connectedness, intergenerational knowledge exchanges and cultural continuity is crucial to the longevity and applicability of indigenous health promotion. Central to the effective provision of cultural-collective health programmes is that they are situated and supported by the therapeutic and sociocultural features of indigenous healthcare settings. These places are within the control of indigenous peoples who will be involved in making decisions about programme outcomes and suitability of resources. The involvement of indigenous community members in all stages of health promotion can ensure that programmes are appropriate and relevant to the contextual circumstances and requirements of their community as a whole. This also includes the physical and psychosocial environment, including broader socio-political and economic contexts. However, more funding is required, as these places often receive very little financial support. Nonetheless, indigenous healthcare settings have an increasingly important role in empowering indigenous peoples' health autonomy and developing their cultural capacity. In my next chapter, I examine the many features and experiences of indigenous community gardens as a cultural-collective activity which can significantly contribute to improved wellbeing and cultural capacity. I will demonstrate that community gardens are an important example of the dynamic relationship between influential factors for wellbeing highlighted in the cultural efficacy framework. Situating community gardens within indigenous communities has the potential to produce multifaceted benefits including empowering factors of sociocultural (re)connectedness and reinvigoration.

Figure 5: Te Puea Marae 1

Chicken Coop adjacent to the māra kai of Te Puea Marae

Chapter 4 Indigenous community gardens and urban wellbeing

4.1 Introduction

In Chapter 3, I argued that improved wellbeing for indigenous peoples can be achieved through the combination of culture-collective initiatives and culturally-loaded places. Cultural efficacy theory provides an important framework for this argument because it identifies sociocultural environmental factors as a main influence for the development of cultural efficacy and capacity. In this chapter, I apply a cultural efficacy lens to the mechanisms of community gardens and indigenous peoples within urban contexts. I argue that community gardens situated within indigenous communities are an important example of a cultural-collective activity that can produce distinctive and multifaceted benefits. I commence Section 4.2 by providing a brief justification of my selection of community gardens as an example of a cultural-collective wellbeing activity. I then provide an overview of the history of urban gardens, and discuss their function as an everyday activity that increases family wellbeing. While there are many well-documented multiple benefits associated with community gardens, I focus on three main cultural-collective benefits for indigenous peoples. First, in Section 4.2.1, I explore the social functions and benefits of gardens. Second, in Section 4.2.2, I demonstrate the cultural features of urban-indigenous community gardens that contribute toward cultural retention and continuity. Last, in Section 4.2.3, I discuss their contribution to nutrition and improved diets for indigenous families. More importantly, these experiences of productivity and altruism for indigenous peoples as they grow their own food within urban environments and provide for others can be integral preconditions for wellbeing.

In Section 4.3, I explore the role of urban community gardens and their place-based features that facilitate the development of cultural efficacy and a multitude of unique and comprehensive wellbeing benefits for indigenous peoples. Next, in Section 4.3.1, I demonstrate the locational features of community gardens which include local activism in contributing to alternative food movements. Yet, paradoxically, while urban food gardens reject neoliberal agendas, they also inadvertently reinforce them. I also show that community gardens are important contributors to localised experiences of food sovereignty and indigenous autonomy. Finally, in Section 4.3.2, I explore how community gardens provide therapeutic experiences for indigenous peoples within urban contexts by increasing land-based sociocultural connections. I demonstrate that community gardens are an everyday place and activity that empowers indigenous family wellbeing. Hence, gardens have significant potential as an indigenous health strategy that produces multi-faceted wellbeing experiences. The potential benefits of garden engagement for indigenous peoples are the wide-ranging benefits gained through empowerment as a result of sociocultural connectedness. The discussion of literature in this chapter supports my later review of research on marae food gardens in the empirical chapters.

4.2 Community gardening: a cultural-collective activity of wellbeing

As discussed in the preceding chapter, although health promotion strategies for improving indigenous health are evolving from biomedical to ecological approaches, many programmes remain underpinned by individualism and a lack cultural awareness (Baum & Fisher, 2014; B. L. Green, 2010). These features of individualism are evident within the various aspects of many health programmes and services including the model, delivery or outcome expectations. I argue that cultural-collective health strategies that are initiated, supported and delivered within indigenous communities represent an important opportunity to improve indigenous wellbeing, while also empowering their autonomy and cultural capacity. Local programmes can increase indigenous autonomy by drawing from local knowledge and expertise to achieve collective health and wellbeing outcomes (Barnett & Kendall, 2011). In consideration of these factors, I have selected indigenous community gardens as an exemplar to examine the benefits of combining a cultural-collective activity with a supportive sociocultural place. As I discuss further below, the justification for my inquiry on community gardens primarily centres on the sociocultural relevance and potentially wide-ranging benefits for indigenous peoples. Although not all community gardens are necessarily driven as health promotion initiatives, their universal underlying function and intention is improved wellbeing as a result of active stakeholder participation. Significantly for this study, indigenous community gardening represents an ordinary and everyday activity that can fulfil both cultural and collective wellbeing requirements to foster holistic family and community health.

Urban-indigenous community gardens are the primary focus of this study for two main reasons. First and foremost, a substantial number of indigenous peoples now live in urban centres (Brand et al., 2016). However, living in urban centres has not improved indigenous people's health, nor their access to conventional health services (Alford, 2014; Dew et al., 2016). Indigenous health studies have demonstrated that ongoing structural barriers continue to impede access to and delivery of health services (P. M. Davidson et al., 2012; Dutta, 2016; Waterworth, 2015). Community gardens offer a more informal, less conventional form of health delivery in urban centres. As a health promotion activity, gardening is generally a less structured, more self-directed and voluntary way of improving family wellbeing (Alaimo, Beavers, Crawford, Snyder, & Litt, 2016), which may therefore be more amenable to urban-indigenous peoples. Secondly, for indigenous peoples, motivations for engaging in gardening may be linked to urban locale related influences of social and cultural experiences, rather than more generalised benefits. For example, as King (2015) argues, community gardens on urban marae provided a space for gardeners to re-enter the Māori world and gain benefit from engaging in reciprocal acts of care that support their wellbeing, and the wellbeing of others. Further, urban-indigenous peoples may feel more at ease in partaking in gardens within their community, because it is a familiar activity that reconnects them to past memories and experiences while creating new memories with their family (Stronik, Nelson, & McLaren, 2010; Wen Li et al., 2010) (see further Section 4.2.2).

Principally, community gardens can be defined as plots of land of varying sizes, where gardening is carried out collectively by community members for the primary purpose of growing fruit and

vegetables. A large majority of urban community gardens are in open spaces that are managed and operated by members of a local community (Guitart, Pickering, & Byrne, 2012; Okvat & Zautra, 2011). They involve people sharing in the formation, maintenance and rewards of gardening. Numerous studies demonstrate that community gardens are multifunctional sites that provide education, recreation and holistic healing opportunities for their community (J. R. Brown, 2012; Earle, 2011; Pitt, 2014) (see further Section 4.3). Community gardens have an extensive history in traditional land use dating from the early nineteenth century and have been important sources of food in times of poverty, war and depression. War gardens were encouraged between 1917 and 1919 in backyards, vacant lots and parks to address the severe food crisis during and immediately following World War 1 (Lawson, 2014).Community gardens, described as 'relief gardens', were set up in the US during the Great Depression of the 1930s to provide a means for the unemployed to grow food to eat (Pudup, 2008). Indeed, during both World Wars, so-called 'Victory Gardens' were an important resource in many communities when food, fuel and other resources were scarce (Hanna & Oh, 2000; Lawson, 2005, 2014). Post-war, momentum and support for gardening significantly decreased as the need for rationing reduced and industrial agricultural systems were reinstated (Naylor, 2012; Ogawa, 2009). The decrease of garden production aided the expansion of an industrial-capitalist food system and fresh food was increasingly replaced with commercially produced food.

Much later, in the 1970s, food gardens went through a rebirth in response to rising inflation, environmental concerns and a desire to build neighbourly connections. The number of community gardens increased in urban areas and they were supported by government programmes as a means to quell the unrest of the unemployed and hungry (McClintock, 2013). While the early history of community gardens in both the United Kingdom and the United States is one of food production in response to economic depression, war, and civic movements, gardens today are more commonly associated with improving quality of life through the production of fresh food and increased physical activity (Kortright & Wakefield, 2010). As Ohmer (2009, p. 398) explains, gardens are linked to community revitalisation by "improving and beautifying distressed communities, promoting sustainable community development, and increasing civic engagement and conservation practices". Health studies have consistently reported over several decades that community gardens contribute to enhanced local environments and improved community, individual, and family health (Alaimo et al., 2016; Kingsley, Townsend, & Henderson-Wilson, 2009; Lainer, Schumacher, & Calvert, 2015). These studies have also shown that people's wellbeing is intertwined with positive experiences of their physical and social environments. Hence, community gardens are regularly employed as community-level health programmes that have the potential to produce wide-ranging benefits for stakeholders.

Indigenous health strategies must be adaptable and responsive to social structural contexts including socioeconomic, cultural and lifestyle factors. I will show that community gardens can respond appropriately and effectively to indigenous people's complex social contexts and wellbeing needs. This includes the prioritisation of cultural and social factors for family wellbeing. Urban-indigenous community gardens have potential as local solutions to reducing hunger and poverty, improving residents' social interaction and civic participation, and promoting healthy diets and lifestyles. Moreover, indigenous peoples may be more inclined to participate in local and indigenous owned and

operated health activities compared to non-indigenous options (Skinner, Pratley, & Burnett, 2016). As Mundel and Chapman (2010) have argued, programmes need to be culturally relevant and not 'done to' indigenous communities. Hence, indigenous community gardens can be an effective means of influencing indigenous participation by entailing features of empowerment, increased capacity, cultural connectedness, and can also facilitate decolonisation processes such as food sovereignty (Cidro et al., 2015; Cidro et al., 2016; Elliott, Jayatilaka, Brown, Varley, & Corbett, 2012).

At the outset, I note there are some limitations on indigenous engagement in community gardens. Gardening is not for everyone, indigenous and non-indigenous alike, whether that is through a lack of appeal, skills, or land. The collective nature of community gardening can also be a barrier due to tensions or conflicts related to shared public spaces and issues of control (Okvat & Zautra, 2011). Further, the location of the gardens may serve to deter rather than entice participation. These location issues extend to culturally-loaded places such as marae, which some Māori may consider unfamiliar or daunting places to enter (see Chapter 5). Yet, while gardening may lack universal appeal within and across indigenous communities, this barrier is not specific to this health activity, or indigenous peoples. All health strategies can face challenges regarding participation for both simple and complex reasons (Montgomery & Schubart, 2010). Nonetheless, as I argued in the preceding chapter, health systems need to provide a broad range of strategies in efforts to improve indigenous health, which includes extending programmes from individualised to cultural-collective models. In the following sub-sections, I review the social, cultural and nutrition benefits of community garden engagement for urban-indigenous peoples.

4.2.1 Social interactions and supportive experiences

The social function of community gardens has been a focus of health studies for many years (Agustina & Beilin, 2012; Alaimo, Reischl, & Allen, 2010; Flachs, 2010). More recently, this focus has expanded to include urban food gardens and their role in the social wellbeing of indigenous peoples (Cidro et al., 2016; P. King et al., 2015; Tam, Findlay, & Kohen, 2014). Indeed, as King and colleagues (2015, p. 17) aptly comment, the significance of gardens for Māori in New Zealand has relevance internationally for indigenous peoples now settled into the everyday living circumstances of cities. He writes:

> Gardening is a deceptively simple activity to grasp, but one rooted in complexity. Gardening refers to a site for basic human sustenance and aesthetic enjoyment, and in growing social ties, relationships reproduce traditions, knowledge and connections … Māori gardens provide spaces to connect and re-connect with the very essence of what it means to be Māori. (p. 17)

This quotation reflects the comprehensive social and wellbeing impact of food gardens. Although considered an ordinary activity, the social interaction and collective action required in community gardening have deeper implications for connecting indigenous peoples with each other, their culture and often new environments. As Wills (2010) argues, urban community gardens may be more about community than they are about gardening. This is because gardens offer a space for people to gather,

share ideas and identify together as community members or indigenous group members. Firth (2011) elaborates that gardens are a social space that can help to build cohesion and vitality within communities. Social cohesion can positively influence health by fostering the mutual exchange of resources and knowledge and promoting cultural efficacy, as people develop belief in their ability to act cooperatively to solve their problems (Mennis et al., 2013). From a health promotion perspective, social capital can influence health and health behaviours in a positive way through experiences of social support and social participation.

The fundamental nature of a community garden entails a reasonable degree of social interaction and the formation of positive networks for individuals and community as a whole. Interaction with community members, family and friends within and surrounding community gardens are social experiences that foster access to social resources and social learning (Alaimo et al., 2016; Alaimo et al., 2010). Alaimo and colleagues' work reviewing community gardens demonstrates that the main wellbeing benefits include positive experiences of helping others, sharing, reciprocity, and learning experiences. These benefits reinforce social connectedness within community groups and a sense of membership, pride and belonging to a community (Lainer et al., 2015; Milburn & Vail, 2010; Northrop, Wingo, & Ard, 2013). Emerging food gardens studies are in agreement that social and place connections contribute to forging a new sense of self and belonging for immigrants to urban centres (Hartwig & Mason, 2016; R. Sampson & Gifford, 2010; Wen Li et al., 2010). As Harris (2014) concluded in his study of 12 African refugees resettling in Australia, food gardens offer a means for vulnerable populations to build community connections and a sense of belonging through reconnection with the purposeful and familiar activity of growing food crops.

Other studies of indigenous community gardens have identified that the social features of gardening can influence health and wellbeing through eating behaviours (Lombard et al., 2014; Mundel & Chapman, 2010; Stang, 2009). For example, Stang's (2009) research examining nutrition interventions among American Indians found that social factors of family and peers influenced eating behaviours through role modelling, peer pressure, and social support. This study recommended capitalising on the social influence of family to make nutritional health strategies involving American Indian or Alaskan Native tribes more effective for collective behaviour change. Stang (2009, p. 1529) elaborated that the central role of family can be crucial for participation in health promotion:

> Because of their strong sense of family and tribal affiliation, American Indian communities present an opportunity to focus substantial nutrition intervention efforts on community-level influences. Elders and community leaders are influential members of Native societies who can influence the beliefs and practices of large groups of people.

Past nutrition interventions have had less success within American Indian communities, according to Stang (2009), because of their focus on individual proximal factors. This includes individualised nutrition education and counselling programmes designed to change knowledge, attitudes, and beliefs about healthful eating. Follow-up reportage indicates that while these programmes have short-term

success, individual knowledge and education improvements are not reliably predictive of long-term changes in dietary intake or health improvement. In another study, Mundel and Chapman (2010) contended that social networks and supports built through gardening increased the wellbeing of urban aboriginal gardeners growing, preparing and sharing food. Mundel and Chapman (2010) further observed that improved health in indigenous communities can be positively correlated with strong social support. Their review of the Urban Aboriginal Community Kitchen Garden project in Canada demonstrated that increased food-related capacities and social support are pathways by which the cultural-collective activity of gardening may positively influence health within a health promotion frame. Yet, Mundel and Chapman (2010) and Stang (2009) argue similarly that indigenous health and healing will not result through increased capacities and social networks alone. As described in Chapter 3, there are ongoing structural and historical reasons for the health issues faced by indigenous peoples. Stang (2009) maintains that indigenous nutrition programmes are limited in achieving collective behaviour change unless proximal and distal influences that impede indigenous health are simultaneously addressed. This includes assessing the impact of environmental circumstances including social contexts and availability of fresh food that affect adherence to nutritional programmes (see Section 4.3). Nonetheless, these studies emphasise that the influence and outcome of social factors are central to the success of gardening programmes.

In Chapter 3, I demonstrated that family can be a central influence on health behaviours and participation in health promotion for indigenous peoples, (Dodgson & Struthers, 2005; Kocher et al., 2017). Similarly, the community garden literature identifies family as a central influence for gardening engagement (Hartwig & Mason, 2016; Lombard et al., 2014; Mazumdar & Mazumdar, 2012). These studies indicate that family interactions and connectedness are a valued social outcome of community gardens. Positive and everyday experiences of collective engagement with family members in gardens through sharing skills, stories and food contributes to holistic indigenous family wellbeing (P. King et al., 2015; Lombard et al., 2014). Family health can be directly and indirectly affected by the provision of fresh food for the table and the social benefits of increased family connectedness. Lombard (2014) argues that for indigenous family members, children in particular, having direct experience with growing food increases understandings of food and its relationship to health. Further, gardening provides outdoor family activity contributing to valuable time spent together undertaking physical exercise, rather than sedentary time spent indoors. Taken together, these studies show that gardens present invaluable opportunities to connect and socialise with other family members and strengthen family ties. Yet, other studies have demonstrated that community gardens can also function as sites of family conflict (Hume et al., 2013; Wen Li et al., 2010). Wen Li et al's (2010) study highlighted that garden tensions can arise due to power negotiations and issues of control within family relationships. In Hume et al's (2013) study of remote aboriginal gardens, family disagreements led to access to the garden and its produce being denied for some family members. While these family conflicts are not limited to community gardens, they can affect family members' participation in gardening.

Despite the potential for conflict within community gardens, a significant number of studies have highlighted that socialising in and around the gardens is one of the more rewarding outcomes of community gardens (Birky & Strom, 2013; J. R. Brown, 2012; Flachs, 2010). Increased social

connections can counter the impacts of social isolation for indigenous peoples who may have moved from their tribal lands into cities (Snyder & Wilson, 2015). While there are very few recent studies that examine the social role of community gardens for urban indigenous families and their urban environments, comparable studies can be found on the experiences of new immigrants. For example, in Hartwig's (2016) study of a refugee gardening project hosted by area churches (Twin Cities, Minnesota, US), the socialisation benefits of gardening emerged in nearly all the focus groups descriptions. Many of the gardeners remarked that friends would accompany them to the garden plots simply to hang out in the garden and enjoy time outside and socialising. Social interactions around the gardens that included sharing a drink with church members or neighbours were reported by 77 % of participants in the early season survey and 59 % of participants in the late season survey. Other studies have similarly demonstrated that social events such as shared meals and health fairs conducted on urban sites were enjoyed by the gardeners (Althaus Ottman, Maantay, Grady, Cardoso, & da Fonte, 2010; Mangadu, Kelly, Orezzoli, Gallegos, & Matharasi, 2016). These studies highlight that community gardens offer important potential for physical and social adaption to new living environments and for wellbeing. Next, I show that the social benefits of gardens for indigenous peoples can also extend to cultural benefits through face-to-face interaction and learning experiences.

4.2.2 Cultural connectedness and continuity

As discussed in Chapter 3, culture remains a central feature of many indigenous people's lives. While cultural factors such as knowledge and obligations may differ within indigenous families and communities, they can be the main influence or outcome of community garden engagement (Kamal, Linklater, Thompson, Dipple, & Committee, 2015; Stronik et al., 2010). Kamal et al. (2015) argue that community garden activities can contribute to the restoration and development of cultural practices necessary for the continuance and renewal of wellbeing for indigenous peoples. Participation in food gardens located within indigenous communities enables indigenous peoples to socialise among family members, share skills and knowledge, and witness or partake in cultural practices. All of these features contribute to the development of cultural efficacy and improved wellbeing (refer Chapter 2). In this section, I argue that urban-indigenous community gardens provide distinct and vital experiences of cultural connectedness (Mohatt et al., 2011), intergenerational knowledge exchanges (Browne-Yung et al., 2013) and cultural continuity (M. D. Auger, 2016). As discussed elsewhere, cultural experiences can provide indigenous peoples with a sense of grounding, identity social connectedness, and purpose within their urban context. Indigenous community gardens not only contribute to the cultural health and wellbeing of indigenous peoples, but also the reinvigoration and continuation of cultural knowledge, language and values. As Corntassell (2012) argues, indigenous cultural revitalisation and self-determination can be upheld in everyday practices of resurgence and decolonisation. Community gardens can further these efforts of cultural resilience. Yet, the cultural benefits of urban-based gardens have received little attention in health studies, despite the potential to improve indigenous health through tapping into the cultural foundations for wellbeing located within their communities. Notably, the sociocultural features located within indigenous community gardens that facilitate distinctive wellbeing benefits may not be readily available in other settings for urban-

indigenous families. The cultural features of community gardening highlighted in this section provide the basis for further exploration in later chapters.

Gardening has been shown to have a multitude of motivating factors, including economic, environmental, political and physical. For indigenous peoples, the space of community gardens located within urban indigenous communities or culture-based settings provides opportunities for a diverse range of cultural exchanges (P. King et al., 2015; Stronik et al., 2010). As demonstrated in the preceding chapter, formulating and maintaining cultural connectedness and identity can be challenging. For example, colonial processes linked to historical trauma have resulted in a 'cultural disconnect' for many indigenous peoples (Dew et al., 2016; Heart et al., 2011). Food gardens provide an informal communal space for indigenous people to meet others of their culture and thus foster connections of sociocultural inclusion, while at the same time preserving and enhancing their cultural identity and understandings, values and practices. Community leaders, experts and older (elders) members can utilise this space for knowledge exchange around aspects of culture and gardening to younger members (Draper & Freedman, 2010; Lombard et al., 2014). Nettle (2014) elaborates that community gardens are places that enable people to develop and disseminate cultural practices and values while establishing a connection to place. She adds that gardens are repositories of traditional cultural knowledge, and centres of expertise about plants varieties, methods of cultivation and the preparation of myriad foods. In urban contexts and within indigenous communities, community gardens have an equally important role as a site for cultural continuity and ultimately indigenous wellbeing. Developing or reinforcing cultural identity can be challenging for many indigenous people, who may experiences difficulties connected to their living environments.

Community gardens studies have demonstrated that cultural connectedness can occur and increase as a result of intergenerational relationships and the sharing of skills and knowledge (Alaimo et al., 2010). Within community gardens all family members can be stakeholders and actively participate, socialise and strengthen their familial and cultural connections (H. Anderson & Kowal, 2012; Bellows, Alcaraz, & Vivar, 2010; Wen Li et al., 2010). Other indigenous studies have shown that building and strengthening cultural and family connections serves as a protective factor against a range of negative forces and health issues, such as substance abuse, mental health issues and social isolation (H. J. Brown et al., 2012; Goodkind et al., 2015; Stuart & Jose, 2014). Intergenerational relationships developed and strengthened within the gardens are a source of cultural connectedness, while at the same time enabling elder-gardeners to provide advice and support to family members within an informal sociocultural setting. For example, Moeke-Pickering et al. (2015) describe kaumātua (Elders) growing and talking about healthy kai in a pilot Māori community garden, sharing vital cultural experiences and happy interactions across generations of whānau (family). Moreover, Moeke-Pickering and colleagues argue that Māori holistic wellbeing is closely intertwined with spirituality and culture and having a solid purpose in life. Other studies have similarly emphasised the importance of intergenerational relationships and subsequent knowledge exchanges that contribute to indigenous peoples' wellbeing and cultural continuity (Big-Canoe & Richmond, 2014; Donovan et al., 2015; Kamal et al., 2015). These studies demonstrate that activities linked to cultural continuity provide indigenous

communities with the foundations necessary to build positive and healthy relationships and the development of cultural esteem.

Recent indigenous studies have expressed concern regarding the undermining of cultural foundations including language, values and practices (H. J. Brown et al., 2012; M. J. Kral, Idlout, Minore, Dyck, & Kirmayer, 2011). For example, Brown et al. (2012) argue that language is a medium for the transmission of cultural knowledge and "knowing your language" is central to every expression of cultural identity and connectedness. In their discussion of challenges to cultural continuity, Big-Canoe and Richmond (2014) highlight several interrelated factors including the passing of elders; not practising cultural activities; less time participating in land-based activities and limited face-to-face interactions with elders. Taken together, these factors have reduced the intergenerational opportunities to learn and practice indigenous culture and knowledge. According to Gendron (2016), the revitalisation of indigenous food networks is one solution to address this intergenerational loss. Her study of 119 Saskatchewan residents in Canada, over half of whom were First Nations peoples, showed that indigenous food networks that entailed local elder support and participation contributed to increased cultural knowledge and the reinvigoration and production of traditional foods. This study highlighted that activities linked to exploration and revitalisation of indigenous foods benefitted from the inclusion of elders. Elders played a pivotal role in teaching harvesting, storage and preparation of traditional foods. The study participants indicated that they were more likely to attend workshops involving elders where traditional knowledge was shared orally in a more "hands-on" approach to teaching.

While there has been limited health research exploring these features within indigenous-led food gardens and the long-term effects for wellbeing and cultural continuity, an example indigenous community garden in practice can be found in Vancouver, Canada. The garden operates with purpose of encouraging urban aboriginal peoples, mostly youth, to participate, learn and work alongside elders. In the gardens, they grow, prepare and eat food while sharing traditional knowledge and skills. The Tu'wusht Garden project was designed specifically for Aboriginal Canadian people living in east Vancouver (UBC Farms, 2014). The mission of the programme was to provide support and opportunities to improve health and capacity by experiencing "seed to table" gardening. The ceremonies and celebrations that mark important seasonal shifts in relation to traditional foods are important. Of note to this study, this community garden project seeks to empower indigenous community members through improved knowledge, capacity and health outcomes.

Urban-based community gardens serve as a vital space for sociocultural interactions between indigenous peoples and, equally importantly, they operate as a place for the production and retention of traditional foods and food practices. Indigenous food gardens can revive and encourage a healthier diet of traditional foods while promoting the restoration of local food economics and food sovereignty for indigenous peoples (Socha, Zahaf, Chambers, Abraham, & Fiddler, 2012; Walter, 2012). Food gardens offer a unique opportunity for indigenous people to have a more prominent role in community activism and cultural continuation by actively engaging in indigenous food sovereignty (see further Section 4.3.1). Indigenous health discourse demonstrates that colonisation and forced assimilation

have had a lasting impact on traditional knowledge and family dynamics, both of which impact access to traditional foods (Akande, Hendriks, Ruiter, & Kremers, 2015; Barnett & Kendall, 2011). For many indigenous communities, there have been significant social and cultural changes since the first contact with Europeans that have profoundly impacted virtually all aspects of lifestyles which were historically grounded in indigenous traditions. Akande (2015) elaborates that for Canadian Inuit these changes eroded cultural values and indigenous ways of life, leading to the current limitations of resources to support healthy lifestyles.

Despite the erosion of some cultural values, studies have demonstrated that food sharing practices remain a sociocultural outcome of community gardens which support indigenous food sovereignty at a community-level (Cidro et al., 2015; Rocha & Liberato, 2013). As Cidro (2015) and Kamal and Thompson (2013) explain, the sharing of cultural foods links indigenous peoples with families, fellowship, community, values, practices and rituals. Kamal and Thompson (2013, p. 5) elaborate further:

> … sharing is considered mandatory for cultural survival and important for spiritual fulfilment. Sharing food is a way to celebrate life and builds community bonds to help unite the indigenous community. Based on the devotion of people to the land, identity and community bonding is deepest applied to country foods.

Bonds are formed between individuals and groups as a result of sharing a common property. According to Kamal and Thompson (2013), the increased sense of collectiveness gained from sharing and exchanging food signifies cultural connectedness and leads to community formation and unity. Yet, while food sharing traditions are still upheld by many indigenous communities, they are no longer a feature of everyday interactions but rather linked to specific activities and ceremonies (i.e. tribal celebrations). In the past, the customs and traditions around sharing food produce in indigenous communities were to ensure that people didn't go hungry (Rudolph & McLachlan, 2013; Sebastian & Donelly, 2013). Today, among indigenous cultures food sharing practices are still considered a traditional cultural value associated with being hospitable and caring for others (Cidro et al., 2015; Taima Moeke-Pickering et al., 2015). Ultimately, community gardens can provide indigenous families with everyday experiences and activities of casual learning, intergenerational relationships, traditional knowledge and food production (Poulsen et al., 2014; Stronik et al., 2010). In urban centre, gardens hold the potential to be places where cultural experiences and knowledges are put into practice and shared. At the same time, cultural identities and knowledges are increased, and this further contributes to cultural reinvigoration and resilience. Next, I explore the most commonly recognised benefits of gardening, which is providing fresh food to improve nutrition. Yet, more important for indigenous peoples are the essential wellbeing experiences of accomplishment and pride in providing food for their families.

4.2.3 Eating well and being well

Actively producing food and improving dietary intake are the most commonly attributed benefits of community gardens for both indigenous and non-indigenous communities (Alaimo et al., 2016; J. R. Brown, 2012; Northrop et al., 2013). Yet, I argue that for indigenous peoples the experiences of self-worth and achievement gained from producing food for their family and community may be one of the more significant influences and outcomes of garden participation. These psychosocial features of community gardens can contribute to the development of cultural capacity of indigenous gardeners through a collective sense of achievement in completing tasks successfully (Alaimo et al., 2016; Poulsen et al., 2014; Teig et al., 2009). Further, gardening participation includes the empowering aspects of individual and collective decision-making, ownership and social support (Alaimo et al., 2016; Okvat & Zautra, 2011). Studies have shown that community garden participants gain a sense of achievement and purpose from their involvement, including seeing their plants progress whilst also sharing their experiences with their fellow gardeners (J. Chan, Pennisi, & Francis, 2016; Egli, Oliver, & Tautolo, 2016; Hale et al., 2011). This development of a sense of purpose or achievement can greatly contribute to mental health and wellbeing. Hence, as community gardeners make changes to improve their locality and health, they also gain a sense of pride and accomplishment, which in turn increases feelings of self-worth and self-confidence (Okvat & Zautra, 2011). A participant in Kassa's (2016, p. 70) study of Black community gardens in Chicago succinctly identified the psychosocial outcomes:

> [community gardens] it's given me a better sense of dignity and self-worth. I can grow this. And I can do this. And I can do this for... and maybe more importantly, I can do this for other people. I can do this for my neighbours, and my family, and my friends, and my community, and it gives you a sense of pride and dignity. So I think that helps deal with the mental, emotional, and spiritual problems that we have. And then you get in. So that's coming from the perspective of a community garden too, right? When you do it with the community. So you get in the gardens, and you get people together, and we're working together. We're getting stronger physically, cause we're doing hard work. We're getting stronger mentally 'cause we're solving problems.

This quotation shows that gardens can contribute to self- and group esteem, which has significant relevance for indigenous people who may feel disempowered by many aspects of their often individualistic urban lifestyles (see Chapter 2). Kassa also highlights integral factors associated with gardening for indigenous peoples which centre on collective effort and wellbeing through working together, sharing and providing food for others. These features of indigenous altruism and productivity arising from gardening engagement reveal subtle and often understated preconditions for indigenous wellbeing (see further Chapter 8).

Along with the psychosocial benefits of community gardens, gardeners can also make a tangible contribution to improved diets for their families by providing fresh and nutritious food. Increased fresh food intake has important health consequences for indigenous peoples who have disproportionately high rates of preventable chronic diseases that contribute to a lower life expectancy than for non-

indigenous peoples (J. Browne, Laurence, & Thorpe, 2009; Freemantle et al., 2014). For example, cardiovascular disease was the leading cause of death (24%) in 2013 among indigenous Australian peoples, and adults aged 35–44 were 10 times more likely to die from coronary disease than non-indigenous peoples of the same age (Australian Indigenous Health InfoNet, 2015). Browne (2009) elaborates that the dietary risk factors for indigenous Australians that contribute to cardiovascular disease include saturated fat from meat and processed foods, lack of fresh fruit and vegetables, high salt intake, excess energy intake, and alcohol consumption. These dietary factors are consistently linked in indigenous health studies to poor nutrition and diabetes and obesity (Gittelsohn & Rowan, 2011; Khalil, Johnson-Down, & Egeland, 2010). Obesity is a growing global health problem for indigenous peoples and a known risk factor for numerous life-threatening health conditions, including coronary heart disease, stroke, hypertension, and type 2 diabetes (Gracey & King, 2009). In a recent health overview report of indigenous Australians for the period of 2012–2013 an overwhelming 66% of the adults were classified as overweight or obese; and of this number, 67% lived in non-remote areas (Australian Indigenous Health InfoNet, 2015). The obesity rates for adults who are of Māori descent are high, representing about 228,000 out of total population group of 668,724 (Ministry of Health, 2016; Statistics New Zealand, 2013a).

Other relevant studies indicate that a significant proportion of indigenous population groups living in the urban centres of Canada, the United States and Australia are disproportionately affected by diet-related chronic diseases (Brand et al., 2016; Elliott et al., 2012). With large numbers of indigenous peoples now living in urban centres with obesity-related issues, health researchers argue that health systems need to take a more comprehensive and nuanced approach to dietary improvement (Foley, Spurr, Lenoy, De Jong, & Fichera, 2011; Gittelsohn & Rowan, 2011). Recent studies have proposed a variety of interrelated nutrition-based recommendations including reinforcing cultural meta contingencies (Bersamin et al., 2014) and increasing traditional food intake (Gates, Hanning, Gates, & Tsuji, 2016). Other recommendations offered by health researchers include placing responsibility for healthy diets on individuals or families (Theodore et al., 2015), and also increasing local awareness of diet and chronic health issues (Singer et al., 2014). Yet, beyond generalised solutions that focus on increased intake of healthy foods, a growing number of researchers contend that obesity-related issues must be considered within larger social, cultural and political contexts in which food choices are made (Guthman, 2009; Litt et al., 2011; Ristovski-Slijepcevic, Bell, Chapman, & Beagan, 2010).

In dominant health discourses, eating less and exercising more are seen as the solution to the indigenous ‘obesity epidemic’ (Guthman, 2011, 2013; Monaghan, Colls, & Evans, 2013). As Kassa (2016) and Coplen (2013) argue, the current discourse has largely failed to acknowledge race and class as factors inextricably linked to obesity and obesogenic environments (see further Section 4.3); in particular how race and class manufacture obesogenic environments and vice versa. Guthman (ibid, p. 67) explains that current solutions to ‘fix’ unhealthy environments (i.e. fresh fruit and vegetables outlets, and redesigning public spaces to encourage walking) are merely “salutary solutions” that “downplay the salience of race and class in explaining the spatial patterning of obesity and defining what constitutes a healthy environment”. She further elaborates that it is naïve and underdeveloped to suggest that “people are fat because they are surrounded by cheap, fast,

nutritionally inferior food and a built environment that discourages physical activity". This has been problematic for indigenous and low-income communities because it shapes that way health systems attempt to mitigate obesity issues but instead end up further exacerbating health disparities. Salutary solutions that do not carefully consider well-established histories and trends can lead to gentrification of areas to be more like those of the wealthy, which then increases disparities by displacing low-income communities with wealthy, often white newcomers. The focus on the obesity epidemic requires acknowledging the role of economic and environmental factors, the food industry and the people behind it.

In summary, engagement in gardens can be viewed as an everyday cultural-collective activity that can promote indigenous wellbeing by conferring a sense of accomplishment among stakeholders, alongside increased social and cultural connectedness. For indigenous peoples, gardening can entail an important family wellbeing activity in which they can prioritise family obligations and requirements over personal benefits (refer Chapter 3). By contributing to improving and influencing family nutrition and diet alongside knowledge sharing, gardeners can obtain a sense of purpose from providing practical solutions. The cultural-collective benefits of gardens are evident in the commitment of a group of people to work together to produce food and enhance collective wellbeing. The multitude of sociocultural benefits resulting from participation in community gardens highlight their crucial function in offering personal and collective meaningful experiences and interactions and so contributing to improved indigenous wellbeing. Next, I review features of the site of community gardens which support health activities and wellbeing outcomes.

4.3 Community gardens: sociocultural empowering places

As I argued in Chapter 2 and 3, the development of cultural efficacy and wellbeing for indigenous peoples can be strongly linked to the environmental influence of indigenous sociocultural settings, in particular culturally-loaded places. These physical places and associated sociocultural factors can contribute to improved holistic wellbeing, and empower indigenous autonomy and capacity to address health issues. In this section, I focus on the site or place features of community gardens, rather than the activity of gardening, to demonstrate their multifunctional purpose and support of indigenous wellbeing. In this regard, I contribute to my central argument that the location of indigenous health activities can directly and indirectly contribute to the holistic wellbeing of indigenous families. By highlighting the role of indigenous sociocultural places as exampled in indigenous community gardens, I also demonstrate the greater influence of sociocultural environmental factors for indigenous peoples' cultural efficacy and capacity than the self- and collective efficacy constructs proposed by Bandura's (1989, 2000a). As I show throughout this section, although indigenous community gardens can be viewed as an everyday place, this may understate their role in wide-ranging contributions to indigenous wellbeing, including increased local activism, food sovereignty and autonomy. As discussed in the preceding section, community gardening is a collective activity with social, cultural, and physical benefits. In this section, I argue that community gardens may represent one of few local sociocultural places that urban indigenous peoples can meet to take collective action for family

wellbeing. The opportunities for improved family health resulting from the distinct and comprehensive features of community gardens also further highlight the important influence of indigenous sociocultural places for health strategies. This includes the role of urban marae and community gardens for Māori health and wellbeing (see Chapter 5).

There is a limited literature reviewing the role of urban-indigenous community gardens and their multifaceted features as specific indigenous sociocultural places, despite the significant population of indigenous peoples now living in cities. Hence, while I have relied on a small number of closely related studies, I have also included generalised literature with comparable features relevant to indigenous community gardens. Moreover, there are locational aspects of community gardens that are neither indigenous nor non-indigenous specific (Barron, 2016; Lainer et al., 2015). Interestingly, many studies have broadly identified community gardens as multifunctional but also contrasting sites, depending on many community-based factors (Poulsen et al., 2014; Veen et al., 2016). These factors include the specific location of the gardens, sociocultural factors, and the nature of participating community members. For example, the opposing views on the functions of community gardens are evident in the various studies that view these sites as: political and apolitical; everyday and restricted; radical and conservative; collective and individual orientated; and as supporting and opposing neoliberalism (Certomà, 2015; J. Chan et al., 2016; McClintock, 2013). McClintock (2013) argues that community gardens should not be restricted to specific functions and can operate as hybrids. Within alternative food movements and urban agriculture, community gardens are and need to be both radical and neoliberal. Explaining this notion further, McClintock (p. 19) notes that "[community gardens] are simply filling the gaps left by neoliberal state retrenchment; they stave off hunger, but may also stave off more political forms of activism necessary to radically reconfigure society". This argument of McClintock's highlights complexity in the functionality of community gardens which I further discuss in this section. Notably, I show that indigenous community gardens also have a complex and multifunctional role within their communities.

Despite these contrasting and complex features of community gardens, studies have consistently demonstrated their commonality as a place for land-based interactions and also a physical refuge from the many external forces or broader issues that impact people's everyday lives (J. Chan et al., 2016; Lawson, 2014). Chan et al. (2016) employ the term 'social-ecological refuges' to describe community gardens as safe, restorative community places that enable community gardeners to reconnect with themselves, each other, and their local environment. Other studies of immigrant gardens similarly describe the sites as refuges or havens in which English language skills are not necessary and there is less stress around being understood, having to translate or feeling judged (Hartwig & Mason, 2016; Wen Li et al., 2010). Kassa (2016, p. 74) sums up the role of community gardens for marginalised Black communities in the South and West Sides of Chicago:

> [gardens act as] safe spaces for neighbours of all ages to congregate, discuss issues happening in the neighbourhood, and ultimately keep the community alive and healthy, gardens become transformative spaces for community building, learning, and

collective healing. Community members become better stewards to the earth, as well as to each other.

Hence, gardens have a significant role for establishing or reconnecting community members to their physical environment or symbolically putting down 'roots' (Wen Li et al., 2010). In New Zealand, King et al. (2015) argue that marae community gardens provides a safe place and vehicle for Māori to interact and connect materially, socially and culturally. Further, marae community gardens offer a routine and respite from the stress of everyday urban living. Other indigenous studies similarly concur that urban gardens are safe places, providing opportunities for (re)connection with food, nature, culture and families within the city (Cidro et al., 2016; Stronik et al., 2010; Wills et al., 2010).

The physical settings of community gardens can influence and inform health and wellbeing behaviours. Together, the physical and social environment of community gardens support wellbeing and social relations, alongside healing experiences and increased supplies of fresh foods (J. Browne et al., 2009; Lombard et al., 2014; Stang, 2009). Recent studies have shown that local community gardens within low income urban neighbourhoods serve as both a meeting place and a vehicle for community members to address local issues and risk factors (Al-Delaimy & Webb, 2017; Ghose & Pettygrove, 2014a; McIvor & Hale, 2015). In this regard, community gardens can foster a strong sense of community as stakeholders mobilise to produce food and take action on wider issues of community health. In urban centres this includes the collective action and benefits of providing fresh and free produce for families, or selling local produce within market stalls (Guitart et al., 2012; Hatchett, Brown, Hopkins, Larsen, & Fournier, 2015). These tangible outcomes of community gardens can provide collective wellbeing experiences of pride, accomplishment and worth (refer section 4.2). Through the combined efforts of stakeholders, community gardens can also make positive changes to their locality, such as the beautification of vacant lots (Poulsen et al., 2014), and increased interaction with green space (Rosol, 2010). The social and physical environments of community gardens do not exist independently of each other, and their relationship governs people's interactions and actions within this setting. As discussed elsewhere, these environmental factors can be constraints or facilitators for indigenous holistic wellbeing and cultural efficacy (refer Chapter 2). Notably, as I will show, the inter-related social and physical environmental factors associated with indigenous community gardens can be linked to important experiences of local cultural-collective empowerment. I argue that these environmental influences and experiences of empowerment can translate to improved indigenous wellbeing within urban centres.

Indigenous academics claim that community gardens are vital place-based healing programmes for indigenous communities which reinforce connections to land, food, culture and identity (Mundel & Chapman, 2010; Stronik et al., 2010). In urban centres, indigenous community gardens are replete with diverse empowerment opportunities for the development of cultural efficacy, learning and action about food security, therapeutic experiences, and community resilience (Pitt, 2014; Walter, 2012). More importantly, aside from the wide-ranging benefits of gardening as a cultural-collective activity, the physical and metaphoric space of gardens presents a politicised site of autonomy and sovereignty for indigenous peoples (Cidro et al., 2016). Yet, community gardens are not without challenges and

contention, principally from governmental forces (see further Section 4.3.1). In the following sections, I highlight community garden discourse that underscores the role of urban gardens as everyday sites of grassroots activism and indigenous empowerment (Milbourne, 2012; Okvat & Zautra, 2011; Rosol, 2012). Emerging studies are demonstrating the increasing role of urban-indigenous community gardens for indigenous food sovereignty and food security (P. King et al., 2015; Taima Moeke-Pickering et al., 2015). Although food production is primarily viewed as the main purpose of community gardens, for indigenous communities it may just be a by-product of their real purpose – which includes developing indigenous health autonomy.

Below I further discuss community gardens and their utility as a physical place of purpose and local action for indigenous peoples. As Milbourne (2012) explains, community gardens represent an everyday and ordinary form of localised action in response to social and environment forms of injustice within disadvantaged urban neighbourhoods. He notes that urban gardens contain various types of spaces – collective and individual – that entail different scales of community action, including addressing the local state's reneging on its support for the socioeconomic wellbeing of specific communities. Next, I review the role of indigenous community gardens in local activism and increasing indigenous autonomy. Then in the last section of this chapter, I will demonstrate that urban community gardens are everyday therapeutic landscapes of social, cultural, political and health significance (Certomà & Tornaghi, 2015; Lawson, 2014; Milbourne, 2012).

4.3.1 Local indigenous autonomy, activism and sovereignty

Over recent years a growing body of literature has shown that urban community gardens both reflect and generate demands for social justice across local environment, food security and socioeconomic issues (Barron, 2016; Ghose & Pettygrove, 2014b; Neo & Chua, 2017). Neo and Chua (2017) argue that in the current context of neoliberal urban restructuring, community gardens provide an effective platform for community mobilisation. In this regard, community gardens are widely considered as grassroots initiatives that can be used to mobilise local community members to counter the ill effects of urban problems that serve to create and perpetuate inequities within indigenous, disadvantaged and low-income communities (Eizenberg, 2012; Pudup, 2008). As Barron (2016, p. 13) elaborates, although community gardens are small scale they have utility for local autonomy:

> Community gardens, being a highly decentralised response to food insecurity and spatial injustice demonstrate the equivocal nature of neoliberal devolution: as fragmented, local initiatives, community gardens are insufficient to counter the systemic inequities that have spawned them. But joined into networks that connect grassroots change-makers to those who hold power, they can model alternatives that drive new policy, steer planners in new directions, and open new channels that make it possible for gardeners to demand and effect change.

Accordingly, community gardens within indigenous communities can provide an important means for indigenous peoples to transform their urban living environments by addressing political, social,

economic and cultural issues (Cidro et al., 2016; Ghose & Pettygrove, 2014a). While there is a substantive body of literature that details the more socio-political role of gardens for mobilising community action (see Barron, 2016; Ghose & Pettygrove, 2014a), I will focus on three main features of relevance for urban-indigenous peoples, namely; local activism, food sovereignty and autonomy.

Community gardens can be a politicised site of local activism for addressing issues of local injustice, including the political marginalisation of indigenous and minority urban populations (Block et al., 2012; Certomà & Tornaghi, 2015; Ghose & Pettygrove, 2014a). As urban environments undergo persistent societal and political changes, community gardens are a direct and tangible means for indigenous peoples to improve local manifestations of larger sociocultural and economic issues. Urban-indigenous community gardens can support improved local food systems by increasing the availability of nutritious foods to indigenous and low-income urban residents. Community gardens can produce a variety of fresh foods, and offer cheaper and chemical free options to those provided by conventional food systems, including supermarkets, and fast-food and convenience stores (Block et al., 2012; McClintock, 2013; A. D. Wilson, 2013). However, several studies have debated whether convenience food or alternative food systems are cheaper (A. Hume, K. O'Dea, & J. Brimblecombe, 2013; Poulsen et al., 2014; Rudolph & McLachlan, 2013). Nevertheless, as Birky (2013) argues, community gardens in lower socio-economic communities have a crucial role for stakeholders who are dissatisfied with conventional food systems and want an alternative food source for their families, and to reduce “food miles” by providing fresh organic local produce. Essentially, food gardens in low-income communities can be considered a cost-effective and politically acceptable measure to increase access to nutritional food.

Ghose (2014a) and Certomà (2015) argue that food gardens can challenge dominant power relations, including the decrease of social cohesion and solidarity links, and ongoing subjugation by exploitative food regimes. Political challenges are evidenced as gardeners contribute to local food systems and reinforce a political stance of subversive rejection of the industrial agri-food system (Lawson, 2005; McClintock, 2013). As producers of local food, community gardens are positioned within variant food movements that include alternative food networks (Beckie, Kennedy, & Wittman, 2012) and agri-food systems (P. Allen, 2010). Alternative food system supporters view community gardens as a means to counter the existing industrial food system and to raise awareness of food-related issues. Alkon (2012, p. 349) succinctly describes the political significance of these alternative food systems:

> ... food movements attempt to address an array of social problems—environmental degradation, economic centralization, and poverty among them—through the creation of ‘‘alternative’’ markets for local, slow, and organic foods. In addition, community food and food justice organizations have taken responsibility for the provisioning of food in low-income and communities of colour, which helps to justify the dismantling of entitlement programs.

Community gardens can be viewed as a local food system response to social concerns about the impact of conventional globalised food systems on food availability, quality and costs. Yet, the

corollary, as indicated by Alkon, is that localised food systems inadvertently contribute to the absolution of government from responsibility for providing social assistance to address the multiple socioeconomic issues prevalent within disadvantaged communities. Interestingly, as discussed in Chapter 3, the neoliberal paradox highlighted by community gardens applies to effective indigenous community-controlled health services that can also serve to alleviate governmental responsibility (Ghose & Pettygrove, 2014b). Notwithstanding, critical studies of community gardens show that while local food systems oppose the notion of neoliberalism, they end up reinscribing to it in practice (Guthman, 2008; McClintock, 2013). This is because community members committed to the development of gardens can become complicit in the construction of neoliberal hegemony by acting as neoliberal subjects who alleviate government from social service provision (Ghose & Pettygrove, 2014a; Ogawa, 2009). Notably, Rosol (2010) adds further that when communities receive government funding it is often minimal, and community volunteers are utilised as cheap labour. The catch is that voluntary engagement for community gardens results in severe cuts in public spending for these projects (Ghose & Pettygrove, 2014a; Perkins, 2010; Pudup, 2008).

Despite the opposing positioning of community gardens, these studies maintain that gardens have an important role in providing an alternative to welfare reductions, urban food insecurity and urban disinvestment for low income communities. Yet, as Corrigan (2011, p. 1233) argues, the reality is that "community gardens cannot alone resolve food security", but "they are able to contribute to improved access to fresh foods on a local level". Also, efforts to end inequities in food access through community gardens do not address core poverty and disinvestment issues within communities (Alkon, 2013; Block et al., 2012; Guthman, 2008). These structural issues remain linked to the current poor health and wellbeing of indigenous peoples. Local activism can be evidenced in urban community gardens, and their efforts toward indigenous food sovereignty through enhancing food security and growing traditional foods (Cidro et al., 2015; Gendron et al., 2016; Taima Moeke-Pickering et al., 2015). Browne (2009) and others elaborate that food insecurity for indigenous peoples includes experiences of insufficient food, hunger and being unable to afford more (Gendron et al., 2016; Socha et al., 2012). As discussed in Section 4.2.3, food insecurity can have a significant impact on dietary intake resulting in poor quality diets which are one of the leading sources of ill-health for indigenous population groups. In the United States, Stang (2009) reported that the dietary habits of American Indians were affected by a lack of access to healthy food within their neighbourhoods. She explained that many urban American Indians now live in neighbourhoods that lack large well-stocked grocery stores, limiting the availability of fresh and traditional foods. These environmental factors affect the feasibility of health strategies targeting indigenous behaviour change. As Stang (p. 1529) aptly concludes, "even the most culturally competent, evidence-based programs cannot improve eating behaviours among individuals or populations who live and work in an environment that does not support or provide healthful food choices". While people can make individual choices about their diet, their decisions are influenced by the food that is locally available and affordable. Still, the cultivation of local food within indigenous community gardens can counter these prevalent food issues. As Moeke-Pickering (2015) and others argue, these gardens support the food sovereignty movement by placing the control of food back into local communities (Grey & Patel, 2015; Rudolph & McLachlan, 2013). Rudolph (2013) suggests that indigenous community gardens are a preferred solution for addressing

food security efforts and the revival of food traditions because they are small enough in scale to be firmly situated in and controlled by the community.

Socha (2012) and others contend that the exercise of indigenous food sovereignty is reliant on autonomy fostered from reconnection to land-based food systems and the associated requirement for political sovereignty (Kamal et al., 2015; Martens, Cidro, Hart, & McLachlan, 2015). Health researchers agree that the government is the largest and most influential actor in the fight against food insecurity, and its cooperation along with that of other stakeholders should be garnered (Elliott et al., 2012; Hallberg, 2009). Indeed, Elliot et al. (2012, p. 8) argue that in order to holistically address food security issues, indigenous peoples "must be engaged as equal partners, with their knowledge and worldview prevailing in decisions within their own communities and also being solicited and incorporated into society-wide and global policies". Essentially, community gardens can be viewed as an effective mechanism through which to build local capacity for improved food quality and wellbeing. This is because community gardens represent a productive and empowering space for individuals to develop capacities as ecological citizens, organise around garden and neighbourhood advocacy, and become engaged in collective action on community issues (Okvat & Zautra, 2011; Pudup, 2008). In this regard, community gardens can be considered as an autonomous place for all stakeholders.

Studies have universally demonstrated that autonomy, both local and collective, is a crucial feature of community gardens (Alaimo et al., 2016; Barron, 2016; Milburn & Vail, 2010). A simple display of autonomy is evident when gardeners set goals for their garden space and display control of their resources and environments (Milburn & Vail, 2010; Okvat & Zautra, 2011). Other gardening research has demonstrated that autonomy in community gardens also contributes to gardeners determining health-promoting changes in their lives and in their community as they become more active in other aspects of community life (Armstrong, 2000; Wakefield, Yeudall, Taron, Reynolds, & Skinner, 2007). These features of empowerment and autonomy can also influence both cultural and collective efficacy (Draper & Freedman, 2010; Teig et al., 2009). As Okvat and Zautra (2011) succinctly highlight, community gardens involve multiple empowerment processes and outcomes such as mastery and sense of control due to the active collective-level control of a community's resources (food, land, tools). Indeed, in urban centres the processes of connecting with others, participating in decision-making, targeting local issues while resisting globalisation (of food production), can be significant empowering experiences for individual and collective autonomy (B. R. Henderson & Hartsfield, 2009; Teig et al., 2009). Other studies similarly highlight that empowered community garden members can be the catalysts for positive change in their communities, especially in low-income or disadvantaged neighbourhoods (Mangadu et al., 2016; Okvat & Zautra, 2011).

Ultimately, for indigenous communities engaged in their own struggles to reclaim traditional territories and rights related to self-determination around their food and health systems, community gardens present a tangible means to empower their collective autonomy (Desmarais & Wittman, 2014). Although wider community issues may be harder to resolve, indigenous wellbeing can be increased from experiences of decision-making and control within their gardening plots. Hence, community gardens as a mechanism for promoting health encompass vital cultural capacity experiences such as

collective efforts to achieve shared goals. This community-level engagement strengthens sociocultural relationships and develops confidence and capacity to act upon acquired and shared knowledge (Ohmer et al., 2009; Rosol, 2012). Community gardens are ordinary and everyday places where indigenous autonomy can be nurtured and developed alongside food production.

4.3.2 Everyday urban-indigenous therapeutic landscapes

As demonstrated in Chapter 2, indigenous sociocultural settings or culturally-loaded places can be viewed as therapeutic landscapes due to their role in facilitating distinct opportunities for engaging in sociocultural experiences and land-based activities for holistic wellbeing. Similarly, community gardens have been identified as everyday therapeutic landscapes due to their local and accessible role in the promotion of holistic health (Barron, 2016; Kingsley, Townsend, & Henderson-Wilson, 2009; Okvat & Zautra, 2011). Indigenous community gardens in urban centres, I suggest, can further be identified as urban-indigenous therapeutic landscapes due to their utility as a place that indigenous peoples can be among their own, and surrounded by their culture while participating in an everyday health activity (Wendt & Gone, 2012a). An important distinctive feature of community gardens is their function as 'everyday' places for wellbeing experiences and health benefits. As I discuss further in Chapter 5, culturally-loaded places such as marae may not be as universal as 'everyday', or accessible to all community members. The combined processes of colonisation and urbanisation have resulted in a cultural disconnection for many Māori from their marae. Conversely, while community gardens may not be a familiar place for all community members, they generally function as an open and accessible public space. Community members can enter the everyday place of garden to socialise and share knowledge while engaging in land-based activities and benefits.

Gardens offer individual and family experiences that contribute to nutritional, physical, social and psychological benefits, as well as the opportunity to become connected to nature. Health researchers agree that contact with nature through active engagement in community gardens can be both relaxing and calming, which is conducive to holistic wellbeing (Milligan et al., 2015; Pitt, 2014). As Hale (2011) elaborates, gardeners' aesthetic experiences within gardens improve wellbeing through nurturing plants and being in nature. Gardeners also increase social wellbeing due to the many values-based experiences of gardening, such as reciprocity, learning, and sharing. Hence, Hale and others refer to community gardens as a behavioural setting health approach that promotes social inclusion and gives rise to positive social and psychological processes that ultimately lead to improved health and wellbeing (J. Browne et al., 2009; J. Chan et al., 2016). Studies have shown that varied therapeutic experiences linked to garden participation contribute to community members' sense of wellbeing and connection to their local environments (Milligan et al., 2015; Sanchez & Liamputtong, 2017). Land is an integral component of indigenous identity and health. It does not just represent a physical space but rather the interconnected physical, symbolic, spiritual and social aspects of culture (Biddle & Swee, 2012; Houkamau & Sibley, 2010; K. Wilson, 2003). Wilson (2003, p. 89) elaborates on the importance of therapeutic land relationships for First Nations peoples:

> It is important to recognize that the land represents more than just a physical location of healing. It must be understood as part of an intricate relationship in the everyday lives of Anishinabek between the physical, spiritual, and symbolic realms of Anishinabek identities. In addition, relationships to the land do not just exist solely on the ground but also in the minds of individuals.

Hence, land relationships enhanced by land-based activities in which individuals participate in their everyday lives are important for physical, emotional, mental and spiritual health. Indigenous academics concur that community gardening not only provides nutritional benefit to support physical health, but gardeners also connect spiritually with their Creator while being on the land (Cidro et al., 2016; Goodkind et al., 2015; P. King et al., 2015). Community gardens can (re)shape place meanings and attachments, thereby effecting specific changes to indigenous people's social environments and cultural re-integration through an everyday activity which facilitates increased engagement with natural environments to foster health and healing (B. B. Brown et al., 2012; Gesler, 2009).

Mundel (2010) and Walters (2012) argue that the everyday activity of gardening can play a strong role in decolonisation for indigenous people. According to Walters (2012, p. 533), gardens "have helped native peoples to unlearn and overcome food dependency from outsiders, undo the damage of westernised diets and heal the land". For example, fresh garden produce contributes to improved indigenous diets to negate the damage of westernised foods through what are essentially decolonising diets (Mundel & Chapman, 2010; Waziyatawin, 2005). One study from Vancouver exemplifies how indigenous urban food gardens can realise a more holistic definition of health (Mundel & Chapman, 2010). The Vancouver gardens coupled institution building with decolonisation efforts, resulting in a process for regaining political, cultural, economic and social self-determination as well as positive identities. The less tangible benefits of urban gardens include building health supporting relationships, creating a safe place for social connection, and increasing connections between culture and nature (Neff, Palmer, McKenzie, & Lawrence, 2009). Walters (2012, p. 532) posits that "community gardens can be spaces where reciprocity, trust, and cooperation can be learned and practiced across social differences, where mechanisms for sharing resources and resolving conflicts can be collectively developed and tried out, and democratic forms of leadership fostered in the common interest". Moreover, gardens offer a sanctuary where people can come together and escape daily pressures and seek advice and social support (Kingsley, Townsend, & Henderson-Wilson, 2009). Indeed, gardens have been described as third places, which act as social settings beyond home and work in which people relax in good company on a regular basis (J. R. Brown, 2012; Veen et al., 2016).

Gardens provide an informal space for cultural and social interactions and learning experiences. As Kingsley (2009) highlighted in his study, these informal qualities of gardens are linked to broad health benefits, including building self-esteem, fostering self-identity, maintaining cultural and social connections, and enabling relaxation. While informality is a general feature of all community gardens (Firth et al., 2011; Milburn & Vail, 2010), I see this informality as offering a pathway to cultural connectedness and identity in indigenous communities (refer Section 4.2.2). These experiences can be crucial for indigenous peoples who through the processes of colonisation and urbanisation may

have become fragmented and alienated from their tribal groups, traditional lands and cultural knowledge (Kingsley et al., 2013; J K. Tobias & Richmond, 2014). Indigenous academics argue that community gardens are places of holistic and place-based healing for indigenous communities which can reinforce their connection to the land, culture and peoples (Mundel & Chapman, 2010; Stronik et al., 2010). Gardens can also provide a sociocultural place for cultural celebrations, decolonising practices and self-identity (Mundel & Chapman, 2010). In this regard, urban food gardens hold significant potential for indigenous peoples' wellbeing due to their function as an informal and empowered haven for multi-faceted wellbeing experiences. At the same time, the physical presence and utility of food gardens in urban centres embodies an empowered and often politicised setting for indigenous peoples to collectively address local food system issues and environmental justice (Elliott et al., 2012; L. Thompson & Kumar, 2011). Finally, urban-indigenous community gardens can play a definite role in providing informal opportunities for health and healing through the ordinary and everyday therapeutic experience of being among fellow indigenous peoples, which is often limited in their daily living contexts.

4.4 Conclusion

In this chapter, I have argued that community gardens are an exemplar of the effective combination of a cultural-collective activity and a supportive sociocultural place. Indigenous community gardening represents an ordinary and everyday activity that can significantly fulfil both cultural and collective wellbeing requirements that foster holistic family and community health. Although community gardens can be considered a simple activity, they can make small yet significant cultural-collective wellbeing improvements through an everyday activity to further highlight that health strategies need not focus on complex and drastic health-education programmes. Indigenous community gardens can be an effective means of influencing indigenous participation by encompassing empowerment, increased capacity, cultural connectedness, and decolonisation processes in food sovereignty. Health systems need to provide a broad range of strategies in efforts to improve indigenous health. Urban-indigenous community gardens represent a cultural-collective approach of empowering experiences for indigenous stakeholders who are exercising some control over their livelihoods and the type and quality of food they and their families consume. Indigenous gardens offer a place to connect and reconnect with the very essence of what it means to be indigenous (P. King et al., 2015). This includes sociocultural experiences of sharing knowledge, skills and produce and identifying together as indigenous community members.

I have demonstrated that indigenous community gardens provide a culture-centred safe haven for family members to witness or partake in cultural practices alongside cultural experts and elders. These features of gardens can contribute significantly to the development of cultural efficacy and improved wellbeing. Further, indigenous cultural revitalisation and autonomy can be upheld in the everyday and ordinary practices of gardening. Community garden stakeholders can make changes to improve their locality and health, while also gaining a sense of pride and accomplishment. Holistic experiences derived from working together, sharing and producing food contribute to indigenous altruism and

productivity, which can be considered as subtle and often understated preconditions for indigenous wellbeing. As indigenous peoples make a tangible contribution to their families improved diets by providing fresh and nutritious food, many are also engaging in learning about the production and retention of traditional foods (McKerchar, Bowers, Heta, Signal, & Matoe, 2014). I have also argued that community gardens may represent one of few local sociocultural places that urban indigenous peoples can meet to take collective action for family wellbeing. The multifunctional utility of community gardens further supports wider urban-indigenous wellbeing. Community gardens can foster a strong sense of community as stakeholders mobilise to produce food and take action on wider issues of community health. They can become a politicised site of local activism to address concerns of local injustice, including the political marginalisation of indigenous and minority urban populations. Yet, these gardening sites are not without challenges from governmental forces; as they endeavour to resist neoliberal forces, they also reinforce them. In this regard, community gardens can operate on multiple scales as hybrids of both radical and neoliberal forces (McClintock, 2013).

Food gardens can challenge dominant power relations by increasing social cohesion within communities, and actively addressing exploitative food systems. As sites of local activism and autonomy, gardens can be utilised as an effective mechanism through which to build local capacity for improved food quality and wellbeing. Stakeholders can actively increase their autonomy by participating in decision-making, targeting local issues and contributing to collective efforts for improved wellbeing, such as indigenous food sovereignty. Essentially, indigenous community gardens offer an everyday therapeutic place with distinct opportunities for engaging in sociocultural experiences and land-based activities for holistic wellbeing. This includes holistic and place-based healing experiences for indigenous communities to reinforce their connection to the land, culture and peoples. In light of these therapeutic experiences associated with food gardens, they are empowering spaces for all stakeholders to (re)establish links to urban living environments and wellbeing. In the next chapter I present my case study of urban Māori in New Zealand. Therein, I review the contextual circumstances of Māori health and the potential role of marae and food gardens as a Māori owned and delivered, comprehensive and distinctive cultural-collective health strategy.

Figure 6: Ruapotaka Marae 1

Touring the community gardens of Ruapotaka Marae with Whaea Jenny

Chapter 5 Māori health, urban marae and community gardening

5.1 Introduction

In Chapter Four, I argued that urban-indigenous community gardens hold significant potential for improving indigenous peoples' health and wellbeing. This is primarily due to their utility as an everyday empowered site and activity of cultural-collective engagement which includes unique experiences of sociocultural connectedness and autonomy. As demonstrated in Chapter Three, health promotion efforts for indigenous peoples can be more effective when situated within urban-indigenous therapeutic landscapes that can draw from a locus of existing cultural foundations thereby developing cultural efficacy (see also Chapter 2). In this chapter, I review and analyse wider literature regarding the contextual circumstances of Māori and marae that underscore the necessity and (re)development of cultural-collective health approaches. For Māori, achieving optimal health and wellbeing has been an ongoing issue since the colonisation of New Zealand by the British in 1840. Over several decades, Māori have faced numerous challenges that have contributed to their poor health today (see further below). These challenges have affected not only their physical health, but also the control and equity of their individual, family, and tribal health (Chant, 2013; M. Durie, 1998; Whitinui, 2011). Yet, as I demonstrate in this chapter, these ongoing issues of contestation highlight the collective resilience and dynamism of Māori, and marae, to adapt and evolve their efforts in self-determining Māori wellbeing. Māori academics argue that past and present health issues have both tested and strengthened Māori resilience and resolve while also underpinning the urgency for and endurance of 'by Māori for Māori' health strategies (A. Boulton et al., 2011; Kingi, 2006; Ratima, 2010). Urban marae and community gardens, I argue, offer an essential setting and foundational support for both traditional and contemporary Māori wellbeing strategies that can address the varying life and living circumstances of Māori today.

In Section 5.2, I commence by presenting a short history and assessment of Māori health and wellbeing. I briefly highlight some of the main events and circumstances that have shaped Māori health from pre-colonial times to today. This is by no means a detailed review of Māori health or the impact of colonial processes. Notable New Zealand academics have already provided important and extensive work detailing this period (see further M. Durie, 1998; Kingi, 2007; Pool, 2015). Nonetheless, I highlight the impact of the Te Tiriti o Waitangi regarding citizenship and equity rights for Māori and their health. I then show that as a result of Treaty processes as exampled in the Tohunga Suppression Act 1907, Māori health rights and collective-cultural health approaches have been severely undermined. Next, in Section 5.2.1, I focus on more recent health systems, events and policies that have evolved into increased control and delivery of Māori health services. Specifically, I review key health systems changes that have taken place from the 1980s involving health policies and devolution of services affecting Māori. While New Zealand health systems are adapting their strategies to support holistic and empowered Māori health provision, there remains further opportunities for increased cultural-collective health approaches within Māori communities. Last, I highlight the recent

Whānau Ora strategy that has developed from the recent changes to New Zealand health systems and the efforts of Māori to regain control of their health and health services.

In Section 5.3, I discuss and justify the selection of marae and community gardens as my case study. I will demonstrate that marae encompass many features and experiences that affirm their functionality within urban-indigenous therapeutic landscapes. Primarily, that is due to the cultural-collective traits of marae, including a space of Māori being, that serve to underpin its important role in the delivery and ownership of holistic Māori health promotion strategies. Health promotion situated within marae also ensures that initiatives are empowering for the marae community and reflect their self-determined wellbeing priorities. These features underpin my central argument that marae are significant producers and products of cultural efficacy. In Section 5.3.1 I will demonstrate that urban marae have an increasingly important role in Māori health and wellbeing. I provide the context of my eight case study marae. These marae all share common traits and experiences that have challenged their establishment or continuance. It is the varying challenges encountered by these marae that have reinforced their resilience and ability to adapt to ongoing urban issues and conditions. In Section 5.3.2, I broadly review marae gardens and demonstrate their importance as an example of a cultural-collective activity that can develop cultural efficacy and ultimately improved Māori wellbeing. I conclude the chapter in Section 5.4, arguing that urban marae have evolved and displayed remarkable resilience and therefore should be incorporated more comprehensively into future Māori health strategies.

5.2 The circumstances of Māori and Māori health

Māori are the indigenous or native peoples of Aotearoa (New Zealand) arriving by waka (canoe) between 1150 and 1300 CE[3]. Immediately prior to European contact Māori had a relatively good life expectancy for that time - over 30 years of age, -and a total population count in excess of 150,000 (J. Reid et al., 2013; Whitinui, 2011). In 1642, historians write that Dutch captain Abel Tasman was the first European to arrive into Te Waipounamu (the South Island of Aotearoa) and make contact with Māori (Michael King, 1996; J. Wilson, 2016; Yarwood, 2005). After Tasman's visit other explorers including traders, whalers and sealers arrived over the years with some remaining so that by the 1830s New Zealand had an approximate non-Māori population of 2,000 (Ministry for Culture and Heritage, 2014; J. Phillips, 2015). Health systems were already well developed and established, and Māori lived in communities of tribal structures and systems of health, justice, education, spirituality and a common language (Orange, 2011; Ratima, 2001). Health researchers contend that at this time Māori experienced poor health from limited food supply and diseases like pneumonia or gastro-intestinal disorders but were otherwise relatively disease-free (Pool, 2015; Timu-Parata, 2009). These studies further demonstrated that the general good health of Māori could be attributed to their lifestyles that included regular vigorous exercise and a healthy diet (Pool, 2015).

[3] Conformité Européene which means "European Conformity"

Much later, by the early 1800s and at the time of increased European settlement, the health and wellbeing circumstances of Māori began to decline. Māori communities were progressively experiencing poor health due to changing living conditions that included sanitation problems, changed diets, and epidemic conditions (Pool, 2015). Many factors have been attributed to the change of health and wellbeing circumstances for Māori, mostly notably has been the wide ranging effects of new settlers and subsequent colonisation of New Zealand by the British (Kingi, 2007; Wirihana & Smith, 2014). First, as new settlers arrived with new skills sets and trading opportunities (R. S. Hill, 2012), they also introduced new diseases and illness. These infectious diseases included: smallpox, measles, typhoid fever, tuberculosis, and influenza. Consequently, Māori health and mortality rates were explicitly impacted by these chronic diseases and the lack of immunity to these new conditions (see further Pool, 2015). Second, the commencement and progression of British colonisation (see below), broadly affected the social, cultural, and economic wellbeing of Māori. For example, colonisation included processes such as forced land dispossession and relocation, assimilation, and also political and social marginalisation (R. S. Hill, 2010; J. Reid et al., 2013; Wirihana & Smith, 2014). As Whitinui (2011, p. 142) summarises, Māori wellbeing was compromised by "the loss of land, poor crop development, and Māori moving away from infected areas to re-establish themselves in areas that were often unfamiliar and less productive". The effect of these factors were evident in the rapid population decline of Māori from a pre-colonial estimation of 150,000 to an unofficial census count of 56,049 in 1851 (Statistics New Zealand, 1997).

One of the most significant and long-term consequences for Māori health and wellbeing has been the legalised processes the ensued as a result of the Treaty. Named after the place it was signed, the Te Tiriti o Waitangi (Treaty of Waitangi) was written in both Māori and English and was signed by over 500 Māori chiefs on and in the weeks following 6 February 1840 (Orange, 2011). New Zealand academics posit that there were many factors that compelled both the Māori chiefs and the British to enter a treaty (Moon, 2002; Mutu, 2010; Orange, 2011). These factors included: the growing number of British immigrants with plans of large scale land purchase; the increasingly unruly behaviour among some settlers; and a growing interest by the French to annex New Zealand (Whitinui, 2011). A core Treaty feature was the intention to protect Māori and regulate British subjects while also securing commercial interests (see Orange, 2011). At the signing of the Treaty, British representatives conveyed to Māori that it was a document of partnership with the Crown which recognised their existing rights (Gillies, 2011; Renwick, 1990). For many decades since the signing, the purported intention and actual wordings have been the subject of contestation among academics regarding its status in law, the transgressions against it, the claims for redress, and the implications for New Zealand's constitution (Mutu, 2010; Salmond, 2012; Te Puni Kōkiri, 2001). Much of the academic debate has centred on the inadequate translations between the English and Māori versions (Kingi, 2007; Moon, 2002). The consequences of signing the Treaty and misunderstandings of its intentions and purpose very quickly became evident for all Māori, including chiefs who refused to sign, as Hill (2016, p. 145) explains:

> New Zealand's indigenous people were soon to learn that colonial occupation involved relentless settler acquisition of their land and other resources, and that British

> sovereignty was non-negotiably indivisible. Within four decades of colonisation, Māori were a marginalised people, largely landless within a settler political economy geared to supplying London with farming produce

For Māori, the Treaty signified the beginning of colonising processes and traditions of imperialism, including assimilation and health policies, that have consistently challenged and impacted the wellbeing of Māori families (Tomlins Jahnke, 2011). The Treaty has subsequently shaped interactions and discourse on colonial and Māori issues concerning health, social justice, education, employment, land settlements, housing and natural resources (Whitinui, 2011). As I show next, the Treaty has had a significant impact on Māori health and health systems.

The Treaty of Waitangi consisted of three articles that encompassed matters such as sovereignty, property and citizenship rights[4] (Durie, 1994; Ryks, Howden-Chapman, Robson, Stuart, & Waa, 2014). Orange (2011) provides the following summary of the Treaty: Article I, Māori cede sovereignty of New Zealand to the British Crown; Article II: In return, Māori are guaranteed full exclusive rights of ownership and use of their lands, forests, fisheries and other possessions, but if they wish to sell any of these, it must be to the Crown; Article III: Māori enjoy the same rights and privileges as British citizens. The main discrepancies of the Treaty are held in the translated Māori version. In brief, while the English version stated the intentions of the British were to protect Māori interests from encroaching settlers and establish a government to maintain peace and order. The Māori text denotes a promise from the Queen to provide a government while securing tribal rangatiratanga (chiefly autonomy or authority over their own area) and Māori land ownership. The main issues of contestation arise from the English version that indicates unequivocal cession of sovereignty and Māori understandings of retaining rangatiratanga. Nonetheless, the Articles are strongly associated with determinants of health due to agreement to provide good government and protection, Māori self-determination and control over their affairs and equity with other people in Aotearoa New Zealand.

Unlike Articles I and II, Article III there has been very little disagreement over the English to Māori translation. Instead, the main contention centres on the guarantee given by the Crown to Māori of ‘oritetanga’ (equality and equity). The English version stated: “In consideration thereof Her Majesty the Queen of England extends to the Natives of New Zealand Her royal protection and imparts to them all the Rights and Privileges of British Subjects” (Orange, 2011). In effect, Māori understood Article III to guarantee the same rights and privileges as British subjects. Specifically, Māori not only had the same status as British subjects, but were also guaranteed (under Article II) the full protection of their customary rights, spiritual history and knowledge, and their tribal customs and lore (M. Durie, 1998; I. H. Kawharu, 1989). Māori health academics argue that this also meant that Māori could expect access to equitable health care not only as a citizenship right but also a Treaty based one (M. Durie, 1998; Kingi, 2007). Yet, following a short period of time after the signing of the Treaty, the Crown enacted policies that disregarded their citizen rights and entitlements and severely weakened the cultural-collective foundations of their health. These colonial processes and policies included the alienation of

[4] English version

Māori from their land, imposing systems based on English law and undermining the practices of Māori law, religion, education, health, language, and culture.

Academics claim that these colonial processes contributed to the need for social justice for Māori regarding the meaning of the phrase "the same rights of citizenship", and the meaning of "equality" (Lashley, 2000; Van Meijl, 2015). The actions of the Crown were in breach of the guaranteed rights of Māori. Māori health rapidly and over the long term suffered under this breach due to inequitable and unequal opportunities from health care systems. As Van Meijl (2015, p. 44) argues that “the abominable socioeconomic indicators of the Māori population testify to the fact that this obligation has been violated systematically since the Treaty was signed in 1840”. The Crown’s denial of article three rights resulted in a lack of proper and adequate education, health services, housing, employment and other entitlements that were delivered to non-Māori (O'Sullivan, 2008). These consequences had a resounding effect on Māori health. In addition, as Durie (1989) posits, Māori had no expectation that their new rights as British subjects would require abandonment of Māori customs. Nevertheless, in the 1900s the Crown introduced policies that criminalised Māori health structures and healing services. One example of this is the Tohunga Suppression Act of 1907 which was implemented by the Crown to effectively prohibit Māori traditional practices of healing. The main intention of this Act was to stop Māori and non-Māori using traditional Māori services of Tohunga (Māori healers and experts). The Crown argued that this Act needed to be enforced due to concerns for public hygiene and Māori health and also a desire to shift Māori towards Western health systems (Dew et al., 2016). This was despite the fact that most Māori were living in rural areas with very poor access to Western medical facilities (Lange, 1999).

Unlike medical officers of that time, Tohunga practiced holistic health practices but were more than Māori healers. They were revered as experts and scared healers, seers or prophets of their communities. Under threat of prosecution, Tohunga were outlawed from conducting spiritual and cultural practices. This had a dramatic effect on Māori wellbeing and knowledge according to Taitimu (2007, p. 85) who argues that “Tohunga were an integral part of Māori society as they treated not only health issues, but also acted as medical libraries ensuring the protection and transmission of a predominately oral knowledge base”. As Chant (2013, p. 97) explains this legislative act had wide ranging consequences for Māori:

> The de-legitimating of the Tohunga at such an essential time in the destruction of Māori communities and ways of life had a significant effect on not only Māori health and wellbeing, but also on their identity as a cultural and political community … While Māori continued to try to follow their traditional practices with the Tohunga, the overwhelming police and military violence towards any Māori breaching regulations or legislation that occurred in this period did in many ways negate challenges to state authority that might otherwise have occurred.

In effect, this deliberate and legislative imposition undermined Māori rights to wellbeing (Article III) and Māori health suffered as did Māori healing knowledge and traditions (Dew et al., 2016; M. Durie, 2011;

Timu-Parata, 2009). Yet, the outlawing of Māori traditional healers and healing practices did little to curb the decline in Māori health. This government action has been highlighted by many academics as compounding the issues of inequitable health outcomes and a breach of Māori rights guaranteed in the treaty (Timu-Parata, 2009). Several decades later, the repeal of the Tohunga Suppression Act in 1962 by the Māori Welfare Act ensured the capacity for cultural revitalisation. Nonetheless, much of the Tohunga expertise had diminished.

The historical impact of colonial processes for Māori wellbeing have been complex involving multi-layered processes of social, political and structural change leading to the disruption of traditional Māori lifestyles. As Kingi (2007, p. 5) explains, "[a]s colonisation took effect, cultural decay resulted in the abandonment of many of the social structures and practices which for hundreds of years had been used to promote and protect Māori health". The population decline of Māori continued swiftly until reaching its lowest point of 42,113 in 1896 (Statistics New Zealand, 1997). However, from this point onwards the Māori population slowly began to recover. Historian Raeburn Lange (1999, 2008) writes that a significant contributor to this recovery was the efforts of several young European-educated Māori politicians and public health leaders. These leaders included Maui Pomare, Apirana Ngata and Te Rangi Hīroa who worked with Māori communities to improve their living circumstances and conditions. For example, as government-appointed Māori medical officers, Pomare and Hīroa liaised with government authorities and Māori leaders in co-ordinating vaccinations and maintaining healthy water supplies in their communities (George, 2010; Timu-Parata, 2009). At the same time, Ngata in his role as Minister of Native Affairs headed a revival of Māori arts which aimed to revitalise Māori culture by advocating pride in Māori identity. Māori academics indicate that at the heart of Ngata's efforts for improved Māori wellbeing was marae development and supporting the building of superior carved houses (Bennett, 2007; Tapsell, 2014).

Today, over 160 years later, Māori population numbers have markedly increased, but remain seven times smaller than the non-Māori population group. According to the 2013 census, New Zealand's population now totals 4,693,000 peoples and 668,724 of this number are of Māori descent (Statistics New Zealand, 2013b). Health studies demonstrate that the overall living conditions and health circumstances of Māori have significantly improved since the late 1800s, yet Māori remain in poorer health in comparison to non-Māori (J. Reid et al., 2013; Te Puni Kōkiri, 2009; Yon & Crimmins, 2014). These studies also highlighted that the rapid migration of Māori from rural communities to urban townships has contributed to these health outcomes (see further Section 5.3.1). Health issues have continued as Māori have consistently higher rates of heart disease (including rheumatic fever and hypertension), chronic diseases and incidences of cancers, mental illness and substance abuse (Barker et al., 2016; B. Robson & Ellison-Loschmann, 2016; Theodore et al., 2015). For example, Robson's study indicated that preventable cancer is a major cause of death among Māori women, with a 25% higher incidence rate that non-Māori. In general, health researchers concur that Māori health today is reflective of social, cultural and economic determinants of health such as inequitable access to housing, medical care, and income, along with a variety of political factors. These factors have all contributed to the gap in health between Māori and non-Māori (see Table 1 below).

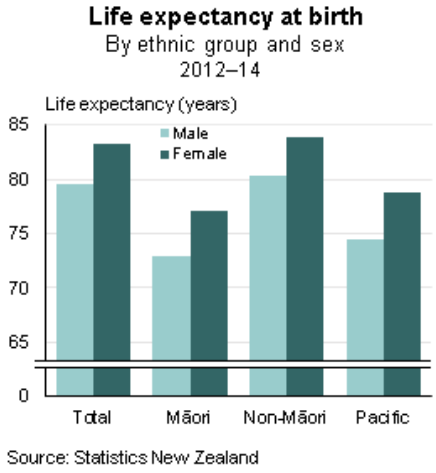


Table 1 New Zealand Life Expectancy (Statistics New Zealand, 2013b)

In the following section, I provide a timeline review of recent health policies linked to Māori wellbeing. I will demonstrate development of health policies and services to focus on improving Māori health and increased self-determination by Māori at individual and family level.

5.2.1 Māori health reforms and Whānau Ora

As a consequence of the ongoing efforts of the Māori renaissance or resistance movements commencing in the late 1960s, the Government was forced to address its Treaty responsibilities to Māori within a number of areas including health (R. S. Hill, 2016; Moon, 2009; L. Smith, 1999). As Van Meijl (2015, p. 33) argues, “it had dawned on the New Zealand government and increasingly also the country’s population that Māori could no longer be denied reparative justice for their dispossession in the nineteenth century”. As a result, by the 1980s the beginnings of important developments for Māori health and wellbeing were underway. These developments arose from the multi-faceted efforts of Māori leaders, organisations and health professionals to increase and reinforce Māori rights to equity in health. In 1981, the Medical Research Council convened the first meeting of associated Māori doctors and other health professionals to discuss Māori health issues and identify priorities for action. Recommendations were made at this meeting for the establishment of community-based services and groups to facilitate Māori access to care and promote preventive measures such as screening for common disorders. In 1984, two important hui (meetings) took place, namely the Hui Whakaoranga and the Hui Taumata, with the aim to increase Māori health strategies. These meetings were viewed as the Department of Health’s commitment to a new Māori health agenda that involved full Māori participation and was pivotal in shaping the new beginnings for Māori health service provision (M. Durie, 1994). Belgrave (2014) contends that Māori leaders wanted a change in health systems where resources and services were provided directly by Māori themselves. Importantly, these Māori leaders made strong demands for a form of devolution within the prevailing health system.

By 1988, plans were in place to devolve a wide range of Māori health and welfare services from governmental agencies to tribal authorities. New health policies were created aiming to improve Māori health outcomes so that Māori achieved improved health similar to that of non-Māori (Article III). Then

as part of the Labour government changes, the Department of Māori Affairs was devolved to the Iwi Transition Agency in 1989. This agency was established in recognition of the significance of iwi and to provide for the incorporation of rūnanga (Māori councils) to represent iwi. The Rūnanga Iwi Act created a subnational governance structure that linked the state to tribal entities and used Māori input and expertise to provide community-based programs and social services (Rūnanga Iwi Act 1990). Although it was repealed soon thereafter, the Act symbolised a new commitment to subsidiarity and governance beyond state agencies. Lashley (2000, p. 17) summarises that the health reform intentions "not only used to transfer power, resources, and responsibility to subnational or local-level government agencies, but "devolution" also restructured the "partnership" between Māori people and the government of New Zealand". Notably, changes included a new funding scheme for the provision of primary health care. Health practitioners could bid for and provide contracted primary care services which opened the way for the establishment of Māori health providers (Chant, 2013). In this regard, Māori organisations could deliver culturally safe health services to their communities with a framework of mainstream health service delivery.

In 1991, Simon Upton, the Minister of Health introduced *Your Health and the Public Health* (1991) and the intention for an extensive reform of the public health systems. It was argued that this would increase health equity and access for all New Zealanders by generating greater efficiency in the system, but that form of language also revealed its neoliberal underpinnings. Upton argued that the primary objective of the reform process was to secure for everyone "access to an acceptable level of health care … [and that] Low income should not create a barrier to quality care" (p. 1). Among Upton's objectives for the new health structures was to support flexibility and innovation in the delivery of health care to the community, and increase the sensitivity of the health care system to the changing needs of people in New Zealand society. The National Party privatised welfare, health and education services giving rise to an marked increase in Māori service providers in the provision of these services to Māori. For example, in education this would entail support for Kōhanga Reo (Māori language pre-school) and Kura Kaupapa (Māori language schools), and in Māori health systems this would enable Māori primary healthcare provision. The 1991 Health Reforms reflected the continuation of the state and economic restructuring and the dismantling of the welfare state. They also resulted in diminished State provision with benefit cuts and the introduction of increased user charges for health care. Nonetheless, Māori provider groups were able to compete with other providers from the public, private and voluntary sectors for health contracts. As a consequence, the number of Māori health providers grew rapidly, and included both iwi and community-based health provider groups (Kiro, 2001).

According to Kiro (2001) Māori providers were an expression of a policy attempt to combine two distinctive government intentions in respect of Māori. Kiro (2001, p. ii) adds that "one intention was the inclusion of Māori to address political concerns such as tino rangatiratanga (Māori control over Māori lives), and the other was the devolution of responsibility for Māori health outcomes to the Māori community itself, in line with other neo-liberal policies adopted between 1984 and 1999". The advantage of the reforms was that Māori providers could now enable Māori communities to become more directly involved in health decisions and service provision. The disadvantage was that it weakened government accountability for Māori health outcomes. Kiro (2001, p. iv) concludes that

health reforms for Māori "must be part of a broader population based and macro policy approach that informs government policies that impact on Māori health and wellbeing". Furthermore, Whitinui (2011, p. 142) argues that "the gradual granting of resources and funding to particular groups from central or local government sectors, highlights how Māori often become recipients of health as opposed to leaders of health". Other academics have pointed out the juxtaposition of the health reforms and devolution of services for Māori. Indeed, the Māori health system's capacity for self-management and creation of corporate governance structures was developed and increased, yet it set Māori against each other in a competitive struggle for limited Crown funding while also adhering to the state on how they should operate (Poata-Smith, 2004). Ultimately, power over funding, policy making and health services remained firmly with the state. Still, while devolution and its policies were a product of the Labour Government's experiment with the decentralisation of state-services to induce competition between providers and create efficiencies (J. Reid et al., 2013), it did provide insight into the requirement to work in-depth with Māori communities. This entailed building an understanding about needs and cultural specificities, and how to tailor services to them. It also revealed the potential of complexities in health systems and programmes for Māori communities and the difficulties for standardised, across-the-board prevention and care programs to be successful in different sociocultural settings.

Further reforms were implemented by 2001 and comprised of three main elements: a majority elected District Health Board, a number of high profile, sector-wide strategies driven from central government, and a health funding package. Under the act, a total of 21 District Health Boards (DHBs) were formed in to centralise hospitals, health services and the health funding authorities (Ministry of Health, 2000). The boards were local organisations responsible for population health and the purchasing and provision of health and disability support services. Māori representation was expected on each board proportional to the number of Māori with the DHB resident population, with a minimum of two Māori members per board (Ministry of Health, 2000). Overall, the health reforms facilitated a significant increase in the number and range of Māori health care providers. These providers were locally based rather than national bodies which enabled local Māori involvement in services and projects and ensured that many projects had benefits for the local community. These reforms also saw the rising emergence of Māori health providers operating as 'by Māori for Māori' service providers (Chant, 2011). As a result there has also been an increase services and treatments based on tikanga Māori (Māori values and practices) and Māori models of holistic wellbeing and health approaches (A. Boulton, Tamehana, & Brannelly, 2013).

The increase in Māori health providers encouraged the (re)orientation of services to cater for the collective needs of families. Reforms in the health sector created opportunities for Māori health systems to develop whānau-based approaches to health and wellbeing. Thus, the Whānau Ora approach to social service delivery evolved from key policy shifts over the last three decades and the efforts for Māori holistic wellbeing reignited by the Māori renaissance movement in the late 1960s. The term whānau ora had been promoted by Durie (1994) as the component of good health that relates to the support from and connection to family. Whānau Ora first appeared in social policy as an outcome of He Korowai Oranga 2002 (The cloak of wellness), the Māori Health Strategy, which was launched

in response to the New Zealand Public Health and Disability Act 2000 (Chant, 2013). The overarching goal of this Māori health strategy was whānau ora: “Māori families supported to achieve their maximum health and wellbeing” (Ministry of Health, 2002:1). This strategy required health workers to consider individual patients as part of a whānau and to take a multidisciplinary approach. The strategy also acknowledged Māori desire for self-determination to regain control of their health, seek their own solutions and to manage their own services. In 2009, Māori Health Minister Turia established the Taskforce on Whānau-centred Initiatives led by Professor Sir Mason Durie to further develop a new approach for the design and delivery of government funded services and initiatives to families. The taskforce gave its report to the government in 2010 which included a framework that focused on whānau well-being (Taskforce on Whānau-Centred Initiatives, 2009). This framework highlighted that providers need to work with the whole family rather than focusing solely or mainly on individual members. Durie (ibid., p. 7) further explained the importance of the framework for family wellbeing:

> The framework is built around whānau aspirational aims consistent with the Whānau Ora philosophy. It recognises the many variables that have the potential to bring benefits to whānau and is especially concerned with social, economic, cultural and collective benefits. To live comfortably today, and in the years ahead, whānau will be strengthened by a heritage based around whakapapa, distinctive histories, marae and customary resources, as well as by access to societal institutions and opportunities at home and abroad

For my study, I argue that this framework supports my contention of the need to provide cultural-collective health approaches based on marae. The taskforce also advised that funders, government and non-government would need to change from a “deficit approach” to a “strengths-based approach” to achieve best outcomes for Māori. This would involve all interested parties to work together with families.

Whānau Ora was launched in two phases, first in 2009 and later in 2014, as it evolved from the coalition between the National and Māori parties after the 2008 general election. Based on the recommendation of the taskforce group, its purported aim is to improve Māori health by taking an approach to health that was relevant for all whānau in Aotearoa. Te Puni Kōkiri is the lead agency for Whānau Ora, with funding streams that come from the Ministry of Health and Ministry of Social Development (Te Puni Kōkiri, 2012a). The strategy directed DHBs to work in partnership with iwi and Māori communities to ensure their decision making effectively leads to whānau ora improvement and supports the achievement of Māori health aspirations’ (Ministry of Health, 2002, p. 15). Underpinning the Whānau Ora strategy is Te Whare Tapa Whā model of Māori health (see further M. Durie, 1985), which encompasses a holistic view of good health that is delivered to whānau with a whānau-centred approach (Te Puni Kokiri, 2012). The strategy, along with the pathways established, has placed expectations on government agencies to ensure Māori health is a priority, and sets out achievable measures for these agencies to meet (Ministry of Health, 2002). Several initiatives have arisen from the whānau ora strategy. Two examples of programmes developed from the strategies is the 2003 Healthy Action: Oranga Kai - Oranga Pumau project which sought to improve nutrition, increase

physical activity and reduce obesity (Ministry of Health, 2003), and the Māra Kai project from the Whānau Ora strategy (see further Section 5.3.2).

To date, Whānau Ora as a government strategy has received both praise and criticism among Māori. Critiques centre on government ownership of Whānau Ora, as Papaarangi Reid argued in the Families Commission Report (2011) that whānau ora is what Māori have always and already been doing. She further contends,

> What worries me about 'whānau ora' is all of it. Whānau ora is what we (Māori) have already been doing. Whānau ora is te kōhanga reo, whānau ora is Mātua Whāngai, whānau ora is Auahi Kore and now our problem is that we have got hung up on the 'policy'. We are waiting for the policy to come out. Waiting for someone to come around and tell us what it is. And that is 'colonisation by policy'. And that is because it's the money getting mixed up with 'mana' again (p. 112).

Other Māori health leaders in the Report have expressed similar concerns noting that Whānau Ora can be viewed as government formalisation of an already established Māori values-based practice. Reid's argument has relevance for marae whose core values have always centre on supporting families and their wellbeing needs. Whānau ora should not be defined or confined to policy and government determined services and outcomes. Nonetheless, as Whānau Ora is undergoing development and implementation into health services, I suggest this strategy makes an important contribution to Māori empowerment in the design and delivery of their own programs, based on their community's priorities. In the upcoming sections, I discuss the context of my case study including marae gardens which I contend are important contributing factors to cultural-collective wellbeing.

5.3 Case study: Marae and Māori health promotion

Māori health systems have evolved and developed markedly over the last thirty years. As I showed in the preceding section, this can be evidenced in the increase of Māori health service providers and the development of cultural-collective approaches to health and wellbeing such as Whānau Ora strategies. From a cultural efficacy theory perspective, the evolution of Māori health systems has important implications because it contributes to the empowerment of Māori to take control of their collective health and develop and deliver a broad range of health services (see Chapter 2). This includes cultural-collective approaches that are located within Māori communities and are based on their diverse needs, priorities and local assets or resources. However, as I highlighted in Chapter Three, there remains a literature and research gap that examines the workings of indigenous-led health promotion located within indigenous sociocultural settings. Indeed, while engagement in community gardens produces multiple sociocultural health benefits, when situated within urban-indigenous therapeutic landscapes these benefits can substantially increase and diversify (see Chapter 4). I argue that urban marae with community gardens empower the development of Māori cultural efficacy and wellbeing. For example, marae food gardens enable the potential for cultural

(re)connectedness and reinvigoration while improving physical and nutritional health. Importantly for my study, research on marae and gardening can provide important insights into the development of cultural efficacy drawn from the combination of cultural-collective activities and settings. In this section I introduce my case study of marae and community gardens. I highlight the contextual circumstances of marae and gardens that underpin their wellbeing role and act as an exemplar of cultural efficacy development.

First, it is important to note that literature on marae[5] regarding their historical origins, cultural traditions and multi-functional purposes has been extensively described and analysed by severable notable Māori academics over many years. Specifically, detailed marae reviews and discussions have been provided by authors such as Ranginui Walker (1975), Paul Tapsell (2002), Adrian Bennett (2007) and Lily George (2010). In this section I review the literature of these authors and others, but the contextual discussion I provide regarding marae is only a small glimpse into the background and functionality of marae. The complexities of marae are briefly highlighted, but many of the challenges and conflicts faced by marae and their families within their own communities, along with an account of external forces such as local and national governments, are not described. It is beyond the scope of this thesis to provide an in-depth review of marae. Nonetheless, below I endeavour to present a broad depiction of marae and their functionality as culturally-loaded places for Māori. I acknowledge that by emphasising and locating marae as culturally-loaded places within therapeutic landscapes literature my review details a more positive depiction of marae with less emphasis on the negative aspects. Indeed, there are numerous ongoing debates and critiques both new and old regarding marae. For example, I have de-emphasised critiques on matters such as: gender roles and restrictions; the development of marae protocols from traditional to contemporary; and the current commercialisation of urban marae (George, 2010; Ralston, 1993; Toi, 2014). While I highlight some of the challenges faced by marae, many other issues remain that are neither minor nor irrelevant which will require further discussion in future studies.

As described in Chapter One, marae for the most part are communal meeting grounds and the cornerstone of Māori society. They can be described as visible symbols of Māori culture, and are dynamic sites that embrace and showcase kin-based values and practices that support Māori identity (George, 2012; H. M. Mead, 2003). Marae comprise of a group of separated, yet interrelated, functional buildings on an area of reserved land. The establishment of marae throughout New Zealand has occurred over many centuries upon the arrival of Māori and can be linked back to earlier Pacific Island settlements (Hiroa, 1927). Historically, and today, the description of marae remains relatively unchanged. As Bennett (2007) aptly explains:

> A marae is a tapu or sacred space, and within or nearby that space are buildings whose form, function and meaning have only come to their present conjunction in (written) historic times. What makes the marae is the combination of the people and the ritual that is involved on a marae, the marae space and lastly, the physical

[5] Marae including: rural, urban, traditional, contemporary and conserved

> buildings. The buildings, particularly carved houses, have additional meaning that they lend to the thread of the story. They themselves represent the whakapapa of the marae, and specifically of the hapū (or sub-tribe) who inhabit that marae (p. 5).

In this regard, marae provide a physical space for Māori to meet and experience the cultural activities and events relevant to being Māori and provide a vital link to identity support and to being a part of a Māori community (George, 2012; Mules, 2010). Tapsell (2017) further emphasises that marae link Māori to their past and current tribal identity:

> The marae is the anchor stone of tribal identity, tying every Māori to their wider communities of origin, genealogically connecting the past to the future and journeying us back into a deep Pacific history of common ancestral origins over 3,000 years old. The marae represents modern day New Zealand's unique social and cultural point of difference (www.otago.ac.nz)

Alongside the physical features of marae that reinforce a Māori identity, is also the cultural-collective experiences and practices of Māoritanga (Māori culture). Certainly, marae are culturally-loaded places in which Māori culture is both seen and heard in the practices of Māori protocols and through the main language of expression, Te Reo Māori (M. Durie, 2006; Tangihaere & Twiname, 2011). Hence, these sociocultural encounters or activities on marae can produce both direct and indirect forms of cultural identity building. Marae provide a community-level venue for Māori to engage in numerous experiences linked to personal, collective, and cultural wellbeing. These cognitive and interactive experiences of both traditional and contemporary aspects of Māori culture within marae enable observational learning interactions and the development of cultural efficacy (George, 2010; Jansen & Jansen, 2013). For example, within marae Māori can partake in events and activities linked to pervasive historically-derived ideas, norms and practices (George, 2012; R. Walker, 1975). An essential element of engaging in marae activities is the experiences gained from interactions among Māori cultural elders, experts, and family members. Tribal members can receive emotional and instrumental support from fellow members which is an important conduit for developing efficacy beliefs.

In Chapter 2, I demonstrated that cultural confidence and capability can be increased by witnessing cultural activities, events and traditions in practice and then taking part. Marae enable intergenerational relationships to develop or flourish as elders often facilitate and oversee the ceremonies and gatherings that take place. Some researchers have identified marae as ‘authentic’ cultural environments where Māori who are disconnected from their identity, language, land and people can reconnect (Adds, Hall, Higgins, & Higgins, 2011; Lilley, n.d). As Lilley (n.d, p. 13) argues, marae “have retained their authenticity in terms of their role of bringing people together and providing a venue that allows Māori just to be Māori”. Nevertheless, Bennett (2007) and others (George, 2012) advise that entry onto marae is not a straight forward process for many Māori, more so for those who are disconnected and unfamiliar with marae processes (see further Section 5.3). Bennett explains that marae have two gateways of access or entry, which I contend can produce obstacles or barriers for

both Māori and non-Māori. The first gateway is the physical entry including the fences or walls of marae that surround the wharenui (meeting house). This barrier can be considered relatively easy to physically navigate; it is the second gateway that has often proved more difficult. He explains further the process of metaphysical entry:

> To open and protect these gateways and to lay out pathways between them and then beyond, guides are required who know the correct tikanga (custom, convention), and use the rituals and ceremonies that have been passed down by tipuna to this generation. Those coming to a marae, beyond merely visiting, actually undertake a journey, from one state to another, transecting realms of tapu, where not following a path correctly may have consequences. To properly enter a marae is to be inducted temporarily into Te Ao Māori, The Māori World, but less figuratively, the Māori way of doing things (p. 24)

Indeed, understanding of these marae protocols provide entry into a Māori place of being, so lack of such understanding may restrict many Māori from attending marae today. Compounding these issues, according to Bennett, is that once within marae visitors are immersed into a world that differs from the once whence they came. Explicitly, the rules of conduct, reasoning and mannerisms are no-longer Euro-centric but rather 'Māori-centric'. In effect, visitors including Māori newcomers can feel like strangers in a strange land and that marae are not always welcoming places but rather unknown and foreign spaces with restrictive or unknown rules and regulations. For example, Bennett (p. 212) argues that there are several marae rules that impose restrictions for Māori and non-Māori alike which can be exampled in the speaking rights of women on marae. Indeed, a large majority of marae as a general rule do not allow women to speak on the paepae (orator's bench). This has been a contentious issue over many years receiving both mainstream and Māori media attention. Although some marae have adapted their tikanga to accommodate female speakers, for the most part many marae stand firm on this long-standing Māori protocol within their region. In Te Hiwi's (2008, p. 16) conference paper regarding Māori identify formation she wrote of the many identity difficulties faced by young Māori and that on marae or through 'cultural identity markers' these issues are often exacerbated. One of her study participants articulated her discomfort:

> *I've been on a marae ... and ... I have felt the wrong colour ... and I have felt judged by my colour. It's ... and I don't know if it's happening or whether I'm being just paranoid, but I'll go onto the marae sometimes and I feel all the eyes, eyeing me up and down ... who's this? ... sometimes you just don't know whether you fit here or there and it's really awful ... I want, I wished I was more Māori, I wished I looked more Māori … (S, 180)*

This quotation highlights that the current challenges for marae and that Māori may be unfamiliar with the processes and protocols of marae, but also that this place of 'being Māori' can in fact, for many reasons, intimidate and make Māori uncomfortable. This can be viewed as a one of the consequences of colonisation and the increasing need for marae to be re-established as a welcoming and familiar

place for Māori young and old. Today, there are over 775 marae throughout both the North and South Island of New Zealand (Te Potiki National Trust, 2017). Marae now include varying compositions and sizes and are located in a wide variety of locations. For example, marae have arisen in urban centres and within tertiary organisations to cater and support the increased population of Māori now living in cities. Many urban marae are limited in land size and buildings and consequently are restricted in hosting specific cultural events such as tangihanga (funerals). Generally, marae studies have shown that while many marae have adapted to their changing environments, circumstances and purpose over many centuries, the fundamental nature of marae has remained relatively unchanged (George, 2010; Tapsell, 2014). Bennett (2007, p. 140) describes both the static and evolving circumstances of marae over time:

> The marae continues to exhibit both resiliency and fluidity when approached with change. Thus, while technology has influenced the architectural form and manner of the various buildings, their Māori fabric has remained unchanging, ancestors either symbolised or directly represented within the buildings. The fluidity is however represented by the new uses to which marae are put in a modern world, uses such as tourism and specifically Māori learning in the Kōhanga Reo, which so many marae now have incorporated into their domain.

While marae have remained resilient by adapting to their changing environments and circumstances, the large majority of both urban and rural marae consistently struggle for sustainability. Some key issues faced by marae include buildings disrepair, low Māori and wider community member participation, and lack of funding opportunities. These marae issues and others were highlighted in a report undertaken by Te Puni Kōkiri (2012d) in 2009 which provided a comprehensive account of current circumstances of marae across New Zealand.

Te Puni Kōkiri invited a total of 744 marae to participate in their study and 544 (73%) of this number contributed. Marae respondents undertook face-to-face interviews or alternatively self-completion questionnaires regarding their marae. Of this group 81% of marae employed between one to five people. In terms of voluntary workers, three quarters (76%) of marae had 20 or fewer volunteers. Each marae provided details on their usage within their communities showing that 35% were utilised two to five times per month. The main users of marae were whānau (98%), hapū (90%), schools and other educational providers (84%) and iwi (or rūnanga) (79%). The respondents were asked of their marae usage during the twelve months prior and noted celebration of an event (88%), wānanga (84%), tangihanga (81%) or corporate activities (66%). During this time a relatively small proportion of marae were used as a base for community services. In this regard, the services most commonly hosted by marae were training and educational services (47%), health services (33%), and social services (26%). Funding was an ongoing issue for many marae as only 51% reported that they had an annual income sufficient to cover normal operating costs. In terms of the future of their marae, 34% respondents reported concerns about the possible loss of their marae history, tikanga or kawa (Marae customs). The main reasons for these concerns included: disconnection with whānau and Māori youth; the loss of key kuia and kaumātua; and the associated challenges in the intergenerational

transfer of knowledge. Interestingly, due to this potential loss of knowledge a significant number of marae (83%) have created and maintained written histories (including audio and video recording).

The key findings of this report aligning to this study show that while most marae are being utilised by whānau, the frequency and numbers are relatively low. Marae disconnect and loss of knowledge remains an ongoing concern among marae members. Importantly, marae were utilised less than 50% for wellbeing services and income or funding challenges remain. This demonstrates that marae could be more effectively utilised to not only earn more income from providing wellbeing services including health services and initiatives, but also at the same time contribute to increasing whānau cultural knowledge and marae attendance. Over many years, Māori health leaders have emphasised that marae have the potential to comprehensively address and support the cultural collective health and wellbeing needs of Māori. For example, another report undertaken two decades ago by Te Puni Kōkiri (1995) highlighted marae as integral health and wellbeing sites for Māori. This was primarily due to their function as gathering places for Māori and their ability to successfully incorporate Māori tikanga and culture into programs. More importantly, when situated on marae the control and ownership of health services and programs are returned to Māori. As Wira Gardiner (1995, p. 5), the chief executive of the Ministry of Māori Development explained:

> An important advantage of this concept is that it provides Māori with an opportunity to be responsible for the implementation and delivery of their own health services. Hence these services can be more responsive to the local needs of Māori and empower Māori to make their own decisions

This report recommended that in order for marae to continue as a valuable cultural resource in the future, it is essential that marae are included in future health strategies and developed as a resource to meet the current and future needs of Māori communities. When marae control and deliver health initiatives they can draw upon a broad range of socio-cultural resources and sources that fulfil not only primary outcomes (i.e. nutritional, economic and physical), but also secondary outcomes such as improved cultural connectedness, confidence and ability (R. Brown, 2010; Hamerton et al., 2014). As Whitinui (2011) argued, improving Māori health is about knowing the diverse contexts Māori live in and Māori being “in a position to decide and solve what’s best for Māori and their health” (p. 149). Marae provide an autonomous environment for Māori self-determination not only in regards to the activities on marae but also for wider health and community issues.

In recent studies, marae have been emphasised as an important site to host health promotion activities and an integral support and provider of Māori wellbeing (Gillies & Barnett, 2012; P. King et al., 2015). For example, in Gillies (2012) study she reported the perceptions of Māori regarding the connection of marae to their health. Information was gathered from surveys and focus groups from over 350 participants, and half of this number was comprised of Māori women. The study participants emphasised that marae were not just a positive and familiar cultural space for Māori, but also a place where sociocultural interaction and connections stimulate notions and practices of positive health. Gillies explained further that kuia (older Māori women or grandmothers) of the study acknowledged

that the physical elements (.i.e. buildings) of marae facilitated a space where cultural, spiritual, social and physical wellbeing flourished. For example, marae provide a place for cultural teaching and learning with Māori language immersion initiatives such as kōhanga reo (language nest). Yet, kuia were aware of a myriad of issues currently preventing Māori from regular and active engagement in the same way they had experienced. They discussed wide-ranging issues revolving around changing times, changing values, work commitments, substance abuse, violence, housing, urbanisation and the challenges of surviving. Of most concern to kuia was the lack of interaction and involvement of Māori youth whom they referred to as 'the lost generation'. Although not lost in a physical sense, but absent from attending marae and understandings of culture, language, and practices. Nonetheless, the study participants argued that marae are a focal point for Māori families and need to be utilised further in the provision of health services. Interestingly, kuia indicated that being on marae was good for their health both physically and spirituality, and in itself was cure for ill-health.

Overall, the venue that hosts health promotion interventions is crucial, and more so for Māori who may prefer venues that are culturally specific, like marae. With the combination of cultural identity building activities and health promotion activities, the potential of marae for improving the health and wellbeing of Māori is enormous. Important to the delivery of effective and appropriate health initiatives for Māori, can be the inclusion of Māori customs and Māori world-views that is situation on marae, and the expectation that local customs and values and traditions will be upheld and practised. Local culturally appropriate interventions and preventions can be essential to improving health status for Māori, because they can also facilitate; community ownership, empowerment, consultation and partnerships. Below, I outline my case study of both marae and community gardens, I outline why each of these factors are particularly useful for exploring the development of cultural efficacy as a result of participation in a collective activity. As context, I outline and describe the circumstances and developments of both urban marae and gardening on marae. I demonstrate the resilience of marae to adapt to the changing circumstances of Māori and its applicability as an urban-indigenous therapeutic landscape.

5.3.1 Marae and Māori of Tāmaki Makaurau (Auckland)

The first component to my case study is urban marae located within the largest Māori populated city in New Zealand: Tāmaki Makaurau (Auckland). Tāmaki Makaurau is home to the three main types of marae which can be broadly categorised as traditional (tangata whenua), immigrant (Taura here) and urban. My eight case study marae includes a mix of these types[6]: three traditional (Ōrākei, Te Puea and Makaurau); one immigrant (Mataatua); and four urban (Ruapotaka, Papatūānuku Kōkiri, Nga Whare Waatea and Manurewa). While I categorise my marae into these three main types, some marae are both traditional and urban. Throughout Tāmaki Makaurau these marae, and others, are differentiated by location, size, purpose, Māori participation, and tribal affiliation. Auckland metropolitan area has over 1.2 million people, which equates to over a quarter of New Zealand's entire population. Within this population is the largest number of Māori of any region totalling over 137,000,

[6] While I broadly identify the case study marae within this typology, it is not exact, and some categorisations overlap

or 15% of Auckland City's total population (Statistics New Zealand, 2006a). At the commencement of this study, 75 marae were reported within the Tāmaki Makaurau region (Te Puni Kōkiri, 2010). The geographic focus of this case study, therefore, centres on this region with the largest group of Māori residents and the significant number of marae that are relatively local and accessible. Below, I demonstrate the circumstances and context of urban marae. Many urban marae faced challenges in their establishment and continuance, and I will show that it is this dynamic nature that underpins their increasingly important role in the delivery and control of Māori health strategies (see Chapter 3). The aim of selecting eight marae for this case study was to extend knowledge of cultural–collective health approaches and the development of cultural efficacy (see further Chapter 6).

Up until 1926, 84% of Māori were living in rural areas within traditional tribal settlements, and by 1966 more than half of this number moved into urban areas. The urban Māori population grew from 62% in 1966 to nearly 80% by 1986 (Ryks, Howden-Chapman, Robson, Stuart, & Waa, 2014; Statistics New Zealand, 2006a). Hill (2016) writes that living rurally for many Māori had become unsustainable principally due to the lack of significant land base and unemployment (refer Section 5.2). Hence, after the Second World War a significant number of rural villages were depopulated as Māori migrated to larges towns and cities in search of work and food for their families (George, 2012). Researchers have shown that the urbanisation of Māori was one of the most rapid shifts for any population group globally (Barcham, 2004; R. S. Hill, 2012). For many Māori families the relocation to urban environments resulted in disconnection from their traditional lands, family and culture (see Chapter 2). Lashley (2000, p. 2) surmises that Māori were undergoing detribalisation as a result of "the breakdown of Māori culture by weakening kinship links, Māori language use, and tribal customs and practices". As studies have demonstrated the migration of Māori to urban centres affected intergenerational relationships and knowledge transmission evidenced in the disintegration of Te Reo Māori (the Māori language) speaking communities in rural areas (Bennett, 2007; George, 2010).

Commencing in the 1950s was a policy of 'integrating' urban Māori into the wider population, also known as 'pepper-potting'. Integration involved Māori families being placed in predominantly Pākehā suburbs, with the hope that they would merge into modern society. As Kingi (2005, p. 6) elaborates, the aim of integration was for Māori to adopt 'healthier' western lifestyles:

> In one sense the policy was successful in that isolating Māori from each other (particularly within urban areas) did much to break-down the more traditional behaviours and lifestyles. However, the policy had a fundamental flaw in that it was assumed that assimilation (though isolation) would have a positive effect on Māori and aid Māori development. However, the opposite occurred, in that the abandonment of traditions and cultural practices did little to enhance urban Māori life and in particular in times of economic adversity

The policies of pepper potting undermined the social structures of Māori, yet it compelled them to (re)established social institutions and build their communities in urban contexts (R. S. Hill, 2012; T. Moeke-Pickering, 1996; R. Walker, 1989). Māori academics argue that as Māori identity and wellbeing

became dislodged from traditional locations and practices, an urgent need was created for these practices to be re-embedded, re-enacted and re-negotiated within urban centres (George, 2012; R. S. Hill, 2012; Meredith, 2000). Consequently, as Māori adapted to their new living circumstances, there was also an increased interest and establishment of marae in urban areas.

As demonstrated in the preceding section, marae fulfil an important sociocultural function for Māori. Hence, urban marae were initially built for Māori living away from their traditional tribal areas including those who had become disconnected from their marae and sociocultural experiences. Urban marae were able to meet the spiritual and cultural needs of Māori, while at the same time functioning as potent symbolic statements of identity (R. Walker, 1989). I posit that this function of marae has become increasingly important over time. As Adds (2011, p. 543) contends that "[t]here are generations of Māori people who are at a loss to their identity and 'urban marae' have provided them with some opportunities to reconnect with kin, or provide a space from which to begin a journey of understanding their identity". Urban marae may attract Māori who are searching for reconnection to their cultural heritage, and therefore ready to begin reclamation journeys (George, 2012). As urbanisation has progressed, however, empirical evidence suggests that less Māori have sought out marae, but this does not undermine their importance (see Chapter 9). As George (2012, p. 437) affirms "while not all urban Māori access local marae, their significance cannot be undervalued [as...] urban marae provide opportunities for the reconnection with, and affirmation of, Māori cultural heritage". Tapsell (2014) concurs and contends that ultimately one of the most important functions of marae is that it is a refuge for Māori, a place that provides a sense of belonging and a forum and outlet for cultural practices to continue in lieu of home marae.

Marae have withstood many challenges and have evolved to more contemporary times of urban living and lifestyles. Tapsell (2002, p. 162) argues of the dynamism of marae, evidenced in their rise with urban centres that represent the resilience of Māori and their adaption, yet importantly an integral support of Māori identity:

> Essentially, the recent urban transformations of marae are best understood as part of a cultural continuum of dynamic adaptation and fluidity that has existed for millennia. The more recent marae transformations, such as those experienced when kin groups moved from Rangiatea to Aotearoa, from pre–European contact to Christianity, from economic and social depression to an era of urbanization and treaty grievance settlements, are part of the continuum of Māori tribal society. Although tribes have been irreversibly entangled with European culture, religions, and values since the mid–nineteenth century, the marae has endured and is still the quintessential focus of Māori tribal identity.

As Tapsell further argues marae are tried and tested institutions designed to negotiate crises. Problems remain for marae in terms of viability and sustainability, in terms of economic and social support. While there is very little current reportage highlighting marae participation by urban Māori, my case study marae visits revealed that all of the marae struggled for consistent and long-term Māori

and community participation. While marae in traditional times were an everyday community hub and gathering place, this is no longer the contemporary reality. Given the wellbeing services and experiences that can access from marae, initiatives to (re)connect urban Māori to marae are integral in the survival of marae. Tapsell (2002) posits that it is the task of Māori to respond creatively to this latest crisis and find new ways to connect with family, identity and core marae values. Speaking of the current challenges for Ōrākei Marae, Kawharu (2010, p. 16) contends that marae are important as a physical place and knowledge base:

> Given the extent of disconnection, rejuvenating the marae, including associated value systems among Ngāti Whātua, is, therefore, essential, now more than ever. This includes finding ways that re-centralise the marae in the lives of the descendant community.

Māori academics universally agree that central to marae survival is people (Bennett, 2007; George, 2010; R. Walker, 1989). Bennett (2007, p. 233)aptly sums up that "marae is defined by its usage, it matters not where a marae is, what median it occupies, what medium is used as the basis for its fabric or the mode of its history – what matters is its current occupation".

Despite the importance of urban marae for both Māori identity and belonging, many urban Māori experience challenges connecting to their both identity and marae. George, (2012, p. 445) explains that "there are urban Māori disconnected from rural ties, who no longer know tribal cultures and histories". She adds that, "there are also many Māori who live along a continuum of stages within cultural reclamation journeys. And within these groupings are individuals whose unique experiences influence how they perceive and express themselves as Māori". Other academics write of Māori identity issues such as the validity of being urban Māori versus rural Māori. As Kukutai (2013, p. 313) argues "urban Māori have also been discursively positioned as less tribal, less culturally endowed, and less "authentic" than their counterparts "at home". This resulted in further alienation for many Māori from their tribal identity formation and marae participation. Alongside the challenges faced by urban Māori of cultural identity and connectedness, marae have experienced a myriad of issues linked to their continuance. Similar to marae throughout New Zealand, each of my case study marae have histories of contestation and challenges that have at times have threatened their continued existence.

An important example can be found in the experiences of the traditional marae of Ōrākei. This marae has endured significant contestation as a direct result of Crown actions which not only impacted their tribal home, but also the tribal foundations of its members over many decades. Ōrākei Marae is located in the heart of Tāmaki Makaurau and belongs to the hapū of Ngāti Whātua o Ōrākei of the wider Ngāti Whātua iwi located in and around the Tāmaki Makaurau. Ngāti Whātua has occupied Tāmaki Makaurau since the 17th century when Te Tāōū, a hapū of Ngāti Whātua campaigned against Waiōhua, the former proprietors of Tāmaki Makaurau (Ngati Whatua Orakei, 2014). By the mid–nineteenth century Ngāti Whātua had relocated its headquarters to the papakainga (home lands) of Okahu Bay in Ōrākei to take advantage of the Pākehā trade and commerce that began flowing into the Waitematā after 1840. The land in Ōrākei was highly desirable real estate, which impelled the Crown

to commence with extraordinary actions to procure the title. The Crown also viewed the marae settlement to be aesthetically displeasing community. Hence, Ngāti Whātua was evicted from their ancestral village in the early 1950s, enforced by the Public Works Act. These acts stripped this once powerful kin group of all their lands and evicted them from their Ōkahu Bay. Tapsell (2002, p. 145) contends that the eviction "provides a poignant example of how the Crown, in pursuit of obtaining desirable real estate in New Zealand at all costs, breached its treaty promise to uphold the customary authority of Ngāti Whātua over their Ōrākei lands and villages". It also subjected the iwi to the humiliation of becoming marae-less. Tapsell further argued that "without their marae the tribe were not only denied their symbolic expression of political, cultural, and spiritual legitimacy over the surrounding ancestral landscape, but were also prevented from maintaining their kin group identity … in effect: cultural genocide" (p. 147). With the removal of the marae there was no symbol on the landscape marking the tribe's presence and tangata whenua presence. Essentially, Tapsell sums up that Ngāti Whātua iwi were "an invisible people".

As a result of Government policy, decades of displacement and loss followed for hapū members who were evicted from their homes and marae buildings burnt. In 1976, the National lead Government announced that uncommitted Ngāti Whātua o Ōrākei land at Bastion Point would be taken for high income housing and parks, which lead to non-violent land occupation and protest in January 1977 for 506 days. By May 1978, 222 protesters were arrested and the temporary meeting house, buildings, and gardens they had established were demolished. It was not until 1991 that the marae was returned to Ngāti Whātua o Ōrākei. The iwi rebuilt their whare tūpuna (ancestral house) at Ōrākei, named Tumutumuwhenua, providing a connection for the tangata whenua with the tūpuna and reclaiming their tūrangawaewae (Waka Maori, 2014). The iwi now controls a property asset base worth in the range of $400 million, with only $3 million derived from Treaty settlement (Waka Maori, 2014). Today, they have over 5,000 iwi members throughout the world. Still, the consequences of crown actions and living within a large city has had long terms for the people of Ngāti Whātua, as Kawharu (2010, p. 16) explains:

> For many Ngāti Whātua o Ōrākei descendants, their marae is familiar but marae knowledge is still limited or unknown. A small fraction of the wider descendant community, perhaps some 5%, actually lives in the Ōrākei community near the marae. Many of those and many others of the wider descendant community have actually very little to do with the marae. The marae may stimulate interest, but it is in fact culturally obscure. Disconnection is not only with marae, but also the wider marae locale …

Kawharu argues further that a whole generation of Ngāti Whātua had grown up without a marae, and without all that marae interactions provide by way of cultural foundations such as protocols and guidance. Overall, Ngāti Whātua has displayed remarkable resilience and adaption, and the picturesque and prosperous circumstances of Ōrākei Marae are strong testament to their collective determination. Other traditional marae within Tāmaki Makaurau have also experienced their own issues with both regional and local government, though not as concentrated as Ōrākei. For example,

in 1980, Te Puea Marae was due to be gifted reserve land next to their marae by Manukau City Council for the use of an ablution block, carpark, passive recreation and, significantly, gardens. However, the land was previously utilised as a rubbish dump and was also of poor quality for gardening because it was based on reclamations from the sea. Nevertheless, Te Puea members continued their pursuit of the land. It was not until 1989 when an amendment to the Local Legislation Bill, with the help of David Lange, that enabled the Manukau City Council to gift the land to the Te Puea Trustees[7].

More recently in the 90s, Makaurau Marae located within a rural area of Tāmaki Makaurau, has experienced both sewage and pollution issues. For example, sludge ponds impacted on access to fisheries and changed the course of the local Oruarangi Creek, leading to odour and midge swarming issues[8]. This marae is also situated within one of the last areas in Tāmaki Makaurau to be connected to the local sewage system[9]. Then in July 2013 a purple dye was spilled into their local Oruarangi Creek causing the entire river to turn purple. The dye was identified as Methyl Violet Liquid EN (dye concentrate) spilt from a nearby Jenner's factory (Boreham, 2013). It has had a devastating effect on the sea life of the river, including oyster beds. The spillage set back the progress of the marae, members of which were undertaking a restoration process of the sea life of the river. As a consequence, the iwi of the marae remain concerned of the long-term effects of the spill for their marae environs.

While traditional marae have encountered a legacy of trials, new urban marae have also experienced their own challenges in establishing and maintaining their marae in urban centres. For example, Manurewa marae experienced council and community impediments to the establishment of their marae in the 1980s. As part of the processes undertaken with the local council to build their marae, the council received over 55 objections and only 19 letters of support. One objector was interviewed by the Midweek News (October 21 1981) as a representative of the Pineharbour Ratepayers Committee and she described the marae plans as 'racist'[10]. Another two local resident's objected to the building of the marae due to their perceived devaluation of their properties and loss of view. The marae committee invited the objectors to view the proposed layout and later withdrew then objections[11]. This marae was completed and open in 1988 and serves not only the pan-tribal Māori of the Manurewa community, but is also the wider community and community groups. Another of the case study marae, namely Ruapotaka, experienced many difficulties in their establishment due to limited land availability. Land was earmarked by the Auckland Council for the marae on a Line Road site. Problems with the site indicated that the size of the location would handicap future expansion and a range of future activities[12] . In addition, the proximity to a large carpark, shopping complex, and police station were viewed by marae members as potential detractions from spiritual wellbeing and important ritual activities that were part of the marae. Another site was suggested as an alternative,

[7]Te Puea marae file, BBC2 4410 A1211 13-6-5-43-1, National Archives, Auckland
[8] Dr Brad Coombes, personal communication, 16 March 2017
[9]Makaurau Marae file, BBC A1211 Box 12C 5-4-3-2, National Archives, Auckland
[10]Manurewa marae file, BBCZ A1211 4410 Box 15 b 5-4-4-2, National Archives, Auckland
[11]Manurewa marae file, BANC A736 1364 Box 19 a 5-4-4-2, National Archives, Auckland
[12]Ruapotaka marae fie, AATE A999 1054 Box 25 c 35-1-2-7, National Archives, Auckland

yet this site was later disregarded due to high cost of providing utilities to the site[13]. Ultimately, the original Line Road site was gifted to the committee in 1981[14]. Ruapotaka Marae has now been in operation within the Glen Innes community for over thirty years.

It is important to note that, traditionally, marae were built on ancestral land that had passed on from one generation to the next. Yet, today urban iwi, whānau and or a community group must acquire a significant amount of funds, apply to council or other agencies for land or grants to purchase land, and then seek permission from the tangata whenua iwi to build. The cost of constructing the necessary marae buildings (i.e. meeting house, dining and toilet facilities) is also substantial. Thus, the establishment of marae in urban centres can be a time consuming and expensive process. Many of the marae of this study have received government funding while fundraising amongst their own iwi and community groups. For example, archival documentation Mataatua Marae reveals some of the financial expenditure of marae building between years 1977 to1987. In an application to Māori Affairs for a marae development subsidy in 1978, the Mataatua committee was initially granted $25,000 towards the marae complex[15]. The committee contributed in excess of $28,000 to the buildings as a result of their own funding raising. Further correspondence details the construction of associated building for the maraes and the costs of $12,000 for carvings. Māori Affairs approved a grant of approximately $3,000 towards these costs. The marae land was provided by Manukau City Council pursuant to ordinances 6 and 15 of the district scheme to use Recreation Reserves for urban marae[16]. Similarly, the marae land for Manurewa marae was owned by the council and was rezoned to accommodate the marae, setting it aside as a Māori Reservation, under Section 439/53 (Manukau City Council, 1985).

Over time, urban marae have evolved and adapted to the changing needs of their marae members and wider community. In efforts to (re)centre and (re)invigorate marae as central contributor for the holistic wellbeing of Māori, many urban marae now provide health and social services. In this regard, these marae provide whānau ora initiatives, not only governmental contracted services but also those instigated by the marae community. Two case study marae highlight the workings of urban marae for their community and offer health and wellbeing services and activities for their communities. Firstly, Nga Whare Waatea established in the early 1990s is a pan-tribal marae and the hub of Manukau Urban Māori Authority (MUMA). MUMA provide integrated services and support for all urban Māori in South Auckland. The marae deliver various social service programmes including restorative justice and youth programmes (MUMA, 2014). Services and programmes include: Tikanga Māori, Tāne Ora and Restorative Justice programmes, Waatea Funeral Services, Radio Waatea, and Waipareira Wrap Around youth service. This marae has additional functions such as a food bank and Kōhanga reo. This marae has also been certified as a private training establishment and has offered driver licence training to approximately 100 individuals in 2011. This marae hosts functions as a Māori Health service provider and provides many Whānau Ora initiatives (refer Section 5.2.1).

[13]Ruapotaka marae fie, AATE A999 1054 Box 25 c 35-1-2-7, National Archives, Auckland
[14]Ruapotaka marae fie, AATE A999 1054 Box 25 c 35-1-2-7, National Archives, Auckland
[15]Mataatua marae file, BBCZ A1211 4410 Box 12**, Maori Affairs correspondence, National Archives, Auckland
[16]Mataatua marae file, BBCZ A1211 4410 Box 12**, Document 8, National Archives, Auckland

Secondly, Papatūānuku Kōkiri Marae hosts programmes for women's health, training and employment opportunities for young people and teaching programmes for parents. The marae caters for youth of the area by providing a skills training service as well as a cultural education programme. The marae facilities are "open to all people for family gatherings, meetings or any function which requires a large hall and dining room"[17]. The marae has been the host of wananga (conferences) discussing organic and sustainable planting, and is a member a member of Te Waka Kai Ora (Organic Food). The main feature of this marae is its expansive gardens set among the urban dense suburb of Mangere. Papatūānuku Kōkiri Marae has large māra kai (food garden) areas with more than 20 māra plots which are utilised by all community members. People from a wide number of ethnic background and ages participate in the gardens. One marae member, Valerie (Interview, Valerie, Papatūānuku Kōkiri Marae, 18 December 2013), summed up the intentions of the marae regarding their holistic services and local community in a follow-up research interview:

> I think it's cos we're open to anything … just open to anything and give it a crack. You know all these health providers, like Turaki health and all those proCare people all want to have a place where they can be able to share the messages. Whatever they be, whether it may be with the Ministry of Health or Education or even from the justice … you know. We're trying to change the kaupapa around how we deliver some of those services. You know tryna be - what do you call it? Like we don't mind being called the prototype you know the initiatives you know, in whatever it may be, "We will start this, and we will see how it goes". We don't mind that. If it involves that people that's us

All of the marae of this case study provide not only the facilities to host government contracted health and wellbeing services, but many also provide these services from their own funds and resources. Māori cultural engagement is just one feature of marae. In this regard, urban marae are comprehensive wellbeing providers and urban-indigenous therapeutic landscapes.

Despite the challenges and issues to the continuance of urban marae, they have proven to be resilient and supported by their families, members and communities that support them. Among the many functions of urban marae is the provision of a Māori place of being for multiple purposes including cultural and social services. Urban marae are not without their struggles from both internal and external forces, in this regard, there would be very few marae that had not encountered challenges and tests to their very existence. This is evidenced in the eight case study marae, each of which have endured, in varying degrees, constant challenges within the realms of economic, social and cultural forces. Yet, in view of the sociocultural functions within cultural-collective settings of marae, they are urban-indigenous therapeutic landscapes. Marae are a place of familiarity, to be among Māori and Māori culture, and to partake in cultural-collective or whānau ora initiatives. In the next section, I demonstrate that marae gardens provide a useful platform for exploring the development of cultural efficacy. In spite of many challenges on both Māori and marae, urban marae can be utilised as

[17] Papatūānuku Kōkiri Marae, Facebook Page, May 2012

important health promoting sites. I argue that this case study provides a useful mechanism for exploring the broader workings of indigenous health strategies involving urban-indigenous landscapes and cultural-collective health approaches.

5.3.2 Marae community gardens

The second component to this case study is the community gardens located on urban marae. As I have argued in the preceding chapter, indigenous people's involvement in urban community gardens can produce a multitude of holistic wellbeing benefits. Studies have shown that food gardening can be directly linked to improved nutritional, social, and cultural wellbeing including the retention and reinvigoration of indigenous traditional foods and food practices (Cidro et al., 2015). At the same time, the physical presence and utility of food gardens in urban centres embodies an empowered and often politicised setting for indigenous peoples to collectively address local food systems issues and environmental justice (Elliott et al., 2012; S Thompson et al., 2011). In this regard, urban marae community gardens hold significant potential for Māori wellbeing due to their function as an informal and empowered haven for multi-faceted wellbeing experiences, including unique experiences of cultural connectedness, identity and continuity (P. King et al., 2015) (refer Chapter 4). Food gardens also represent an important opportunity to revitalise and strengthen Māori agriculture systems.

Prior to European arrival, Māori communally owned and worked their lands to produce food for their wellbeing. Māori relied on cultivated and uncultivated plants such as bracken fern root and cabbage trees as sources of starch, to supplement protein derived from hunting and fishing (Furey, 2006; Roskruge, 2011). At this time, Māori agriculture was defined as a form of shifting cultivation based on subsistence crop economy (Hargreaves, 1963). Tribal communities managed food sites for plants to grow, access for harvesting, and the distribution of produce post-harvest (Roskruge, 2011). Nevertheless, by the 19th century colonial processes resulted in significant changes to Māori food crops and gardening practices. Notably, Māori communities struggled to address the challenges of massive land confiscations, economic exclusion, and the ongoing disruptions to communal life (Viriaere, 2015). As I mentioned in preceding sections, the Crown enforced individualisation of Māori land titles to reduce Māori communally ownership which was viewed as a hindrance to land improvement and development by European settlers. Viriaere (ibid.) argues that the contentious actions of the government were not directed at benign activity of Māori gardening, it was about access and control of resources, and therefore about power. For example, in the late 1860s the iwi of Tūhoe had a significant proportion of their most productive customary lands (Te Urewera) confiscated and were forced off their lands (Māori Law Review, 2014). While Tūhoe leaders were non-signatories under the Treaty of Waitangi in 1840, the Crown nonetheless assumed sovereignty over their territories. The ensuing wars and land dislocation created immense hardship for Tūhoe who then endured widespread starvation and loss of life. Only recently, in 2014, Tūhoe reached a settlement agreement with the Government regarding these Treaty breaches. One of the most important aspects of the Deed of Settlement for Tūhoe was the return of governance of their customary lands of Te Urewera, a financial redress and the acknowledgement of Treaty breaches (New Zealand Government, 2013; Ngai Tūhoe, 2014). Nonetheless, in addition to the long term effects of the Crowns

political actions, the processes of urbanisation also impacted Māori agriculture which included the loss of Māori cultivation knowledge and traditions alongside the adoption of new technologies, methods and tools (Furey, 2006).

Today, marae food gardens provide a means for urban Māori to (re)connect with family members and also partake in intergenerational learning experiences, not only regarding gardening or food practices, but also cultural traditions and knowledge. Intergenerational experiences undertaken within marae gardens involve face-to-face and practical participation under the guidance of kaumātua and or experts who can provide gardening and traditional food growing advice. In Moeke-Pickering's (2015) study involving 10 Māori participants regarding māra kai and engaging in traditional kai (food) gathering, many spoke of the importance of intergenerational relationships for retention of Māori food practices and knowledge. These participants also indicated that healthy food and wellbeing was derived from experiences of sharing happy interactions with all generations of their family and extended family. Moeke-Pickering made the point, based on the discussions of the Māori participants, that 'healthy kai' is itself medicine for Māori, because "it is good for the spirit and the body, and is a vital connection to history, ancestors and the land" (p. 36). Active engagement in cultivating and harvesting traditional foods also served to strengthen connections to their land and provide therapeutic experiences of place.

Central to Moeke-Pickering' study was to provide understandings of Māori food security and food sovereignty issues. This recent study and others have highlighted food security concerns for Māori, and report a need for stronger community activism around food politics to address issues regarding Māori access to nutritious food and retention of traditional foods (Hutchings et al., 2012; McKerchar et al., 2014). These concerns among Māori communities were identified as control of land (ownership and access), growing and distribution of local food, organic food production (pesticide free and without genetic modification), income and jobs, and reducing Māori inequities in health. As Moeke-Pickering (2015, p. 36) further explains, additional work must be undertaken to increase food access and reduce barriers to Māori health resulting from "colonisation impacts, living in urban settings, dependency on supermarkets and lack of educational programmes about nutrition and health". Recommendations from the studies of McKerchar and colleagues and Moeke-Pickering correspondingly indicate that addressing Māori food issues could positively benefit from local Māori communities working together to support initiatives such as community gardens or marae food gardens. Thus, marae food gardens can comprehensively contribute to maintaining, protecting and enhancing Māori cultural knowledge and practice whiles also promoting Māori values. In essence, these studies underscore the role of marae regarding fresh local food production and the revitalising of traditional kai as a platform to improve food security for Māori.

Situating food gardens on marae can be viewed as culturally responsive, and may also lead to reinvigoration and development of traditional Māori skills in working with the land (Earle, 2011). Food gardens that are located on marae can be instrumental in creating and supporting people's efforts to establish a sense of connection or belonging and about grounding people to find a sense of purpose, not just to community, but to land and to nature (B Turner, Henryks, & Pearson, 2011). There has

been resurgence in gardening initiatives within the Māori community (McKerchar et al., 2014, p. 5). Research results highlight that indigenous foods for Māori provide many benefits for sharing, community culture and cultural identity and access to traditional Māori foods is important for nutritional wellbeing (Wham, Maxted, Dyall, Teh, & Kerse, 2012). Over time as the customary practices associated with harvesting, growing and preparing traditional foods diminished, so too has the associated knowledge base and practices (Forster, 2011). A recent paper that explored current efforts to improve Māori food security through revitalising traditional kai, found that Māori were proactively pursuing this goal (McKerchar et al., 2014). Revitalising traditional kai, through marae gardens, has considerable potential to improve food security for Māori, both directly in terms of food supply and by providing income, and warrants policy and practical support.

Of particular interest to this study, is Te Puni Kōkiri Maara Kai programme launched in 2009 as a Whānau Ora initiative. Maara Kai was one of three social assistance programmes, including Kaitoko Whānau and Oranga Whānau. The main aim of Maara Kai was to increase the level of involvement by Māori into community gardening projects and produce health, financial and social benefits (Te Puni Kōkiri, 2012b). The programme signalled high level investment in marae community food gardens. At the launch, the Minister of Māori Affairs, the Hon Dr Pita Sharples (2009) outlined the main benefits of Maara Kai were to promote self-sufficiency, wellbeing, good nutrition, and health activity, sharing of gardening knowledge, including customary techniques and promote community cooperation. Cram (2010, p. 5) posits that Maara Kai was designed to promote gardening and "enhance the ability of Māori communities to feed themselves, while also being a vehicle for health promotion, leadership development, and social and financial benefits". The core notion was to empower communities and extended families to support families as a whole rather than individuals within an institutional context (Te Puni Kokiri, 2012). Participation in the gardens would encourage the connection between Māori and land, while connecting whānau, hapū and iwi. Te Puni Kōkiri offered small grants to marae, kōhanga reo, school and Māori communities to meet the setup and operation costs of community food gardens. Maara kai grants were offered to Māori communities groups throughout Aotearoa, with the main outcome being the project must benefit a local community. The programme was designed to promote gardening and "enhance the ability of Māori communities to feed themselves, while also being a vehicle for health promotion, leadership development, and social and financial benefits" (Fiona Cram, 2010, p. 5). A lump sum grant covered garden bed construction, garden tools, composting equipment and tools. Resources such as equipment, expertise and money are offered to develop and implement gardens on urban marae. The first year of the Maara Kai project resulted in 278 gardens (Te Puni Kōkiri, 2012b). Three marae in this case study had successfully applied for this funding to assist with their garden start-up costs.

On the whole, there are very few studies that examine the holistic benefits derived from community garden experiences on urban marae for Māori. Fortunately, a very recent exception is King's (2015) research involving five homeless men gardening on Ōrākei marae in central Auckland, New Zealand. This study explored how, through gardening and other everyday practices, a group of homeless urban Māori men found respite, reconnection, a sense of belonging, and remembered Māori ways of being. King demonstrated that the garden provided a safe place that enabled the gardeners to re-enter the

Māori world and mutually benefit from engaging in reciprocal interactions that supported their wellbeing and the wellbeing of others. As I alluded earlier in this section, gardening can be considered an ordinary activity, yet when situated on marae it presents an opportunity for Māori gardeners to connect and belong relationally and culturally to their land and fellow Māori. Also, the marae gardens offered a means for the men to implement cultural practices linked to food preparation and consumption, while also affording time and space to prepare their food, free of fear of being moved on. Ultimately, King's study showed that marae gardens provide a 'Māori space of being' and enabled a means to [re]connect into the material, social and cultural space of marae and improve their wellbeing through the cultivation of fresh food. This notion is central to the premise of this study and is explored further within the upcoming discussion chapters of this thesis.

5.4 Conclusion

In this chapter, I have argued that marae offer an essential setting and foundational support for Māori wellbeing strategies. Overall, I have demonstrated the dynamism of Māori, Māori health and marae. The interrelated contexts of adaption and development for both Māori health and marae underpin their important role in future health initiatives. The challenges for Māori health and wellbeing remain ongoing despite the recent increases of Māori health providers and Māori-centred initiatives such as whānau ora. Cultural-collective approaches to health were an integral component to the holistic wellbeing of Māori prior to colonisation. As evidenced in health systems reforms towards family-oriented and holistic approaches for Māori wellbeing, these approaches are being revisited. In accordance of Article III of the treaty, Māori have a right of equity and control in their health as New Zealand citizens. Since the Māori renaissance movement of the 1960s, which ignited the reinvigoration of Māori culture and language, progress has also been evidenced health systems development. Māori service providers and Māori-specific programmes have increased as whānau ora initiatives have been implemented. Nevertheless, there remains scope for further development or adaption of health systems to provide more in-depth cultural-collective services that are grounded within marae settings. In this regard, not only are Māori empowered in the provision of their own health services, but so too are marae.

I have argued that marae are crucial contributors or supports to the empowerment of Māori cultural efficacy and wellbeing. Indeed, urban marae combined with community gardens enable the potential for cultural (re)connectedness and reinvigoration while improving physical and nutritional health. Yet, as I showed, marae are no longer a central feature in the everyday lives of Māori and efforts to improve this situation can have important benefits for Māori and marae wellbeing. Each of my case study marae and their gardens provide important contexts for exploring and understanding their interrelated contributions to the holistic wellbeing of urban Māori. Marae, for example, have the potential to combine important cultural identity building activities and health promotion activities. This is essential for urban Māori who prefer the cultural-collective environment and experiences of marae but no longer reside or are disconnected from their tribal home marae. Despite the challenges and issues encountered by urban marae, they have proven to be resilient to adapt to the changing needs

of local Māori and the wider community. Indeed, urban marae still provide essential sociocultural functions and services that align to urban-indigenous therapeutic landscapes. My case study on community gardens located on marae demonstrates that gardening initiatives can be particularly appealing for Māori beyond food production. This is because they are a medium for passing on traditional knowledge, bringing together families and drawing from the cultural foundations located within marae. Importantly, gardens also provide the physical means to connect to their ancestral links with land. To this end, I have justified the need to explore the workings of Māori engagement in community gardens located with urban marae in the development of cultural efficacy. Next, in Chapter Six, I explain the research methods I used and the underlying methodology that guided them.

Figure 7: Papatūānuku Kōkiri Marae 1

Reviewing the large community gardens with Māra Kai manager Lionel

Chapter 6 Investigating the development of cultural efficacy for indigenous peoples

6.1 Introduction

In this chapter I present my wider methodology and the specific methods used to investigate the development of cultural capacity among 35 urban Māori from eight marae in Tāmaki Makaurau, New Zealand. I demonstrate that the kaupapa Māori research approach (Pihama, Cram, & Walker, 2002; G. Smith, 1997) is an appropriate choice to guide my qualitative exploration of the Māori gardeners' perspectives of their urban marae garden participation. I begin in Section 6.2 with a general description of my methodological approach and explain why qualitative methods were necessary in this research. I justify the application of kaupapa Māori and cultural efficacy theory to frame my research with and within urban marae communities. Ethical considerations are reviewed in Section 6.3. I emphasise the ways in which I endeavoured to ensure that this research respects and protects Māori and their knowledge, skills and expertise. I describe my research relationships with the study marae and the ethical dimensions of undertaking research with marae. I then reflect on my positionality and the limitations to this research. In Section 6.4, I detail the research methods applied to this study, and describe the research setting, participants and interviews. I also provide some personal reflections on events that occurred during the collection of data. Next, in Section 6.5 I outline the specific methods used to analyse the respondents' data. In particular, I review the method of coding I employed and how that process was completed. My chosen methodological approach enabled a focus on the development of cultural capacity within urban communities and connections to indigenous peoples' wellbeing.

6.2 Methodological framework

The indigenous kaupapa Māori research approach and cultural efficacy theory form the conceptual framework of this study and have inform my qualitative research methods, ethics protocols and data analysis. This theoretical and methodological framework is central to achieving my research aims, primarily because it is built on a philosophical foundation that privileges and empowers indigenous knowledge, beliefs, values and practices (Ngā Pae o te Māramatanga, 2012). This is essential given that my research involves Māori respondents and their knowledge and practices in and around gardens on marae. Numerous indigenous academics have extensively defined, reviewed and critiqued indigenous methodologies (Hart, 2010; Kovach, 2009; Ritenburg, 2014; L. Smith, 1999) and their work has assisted me in selecting my indigenous research approach and associated methods. I do not intend to re-explain or redefine indigenous methodological approaches in detail in this chapter, but rather to justify the application of an indigenous approach to my research. Alongside my methodological justification I also identify specific elements of this research that vary from the more commonly known approaches of indigenous research. I am not suggesting that there is a checklist approach to indigenous research, but I posit that methodologies need be flexible to develop as part of the research process.

Research methodology discourses highlight the many difficulties in constructing and implementing generic indigenous research processes due to the varied nature of indigenous participants, their settings and circumstances (Jackson, 2015; Kovach, 2015; Kurtz, 2013; Martin & Mirraboopa, 2003). I concur with Kurtz (2013) who argues that research approaches need to be intuitive, organic and fluid due to a diverse array of factors that can be encountered while undertaking indigenous research. For example, fluidity is especially relevant when the cultural protocols guiding research processes vary according to differing tribal practices within indigenous communities. In addition, marae and their gardens sites, encompass both formal and informal cultural procedures that are often dependent on the research respondents and their proclivity for cultural protocols. Indeed, colonisation and urbanisation have severely impacted indigenous knowledges globally, including protocols and language ability (Axelsson et al., 2016; Gracey & King, 2009). Throughout this section, I highlight important elements of this research approach that are applicable to my study. These insights serve to highlight the necessity of employing a flexible indigenous methodological approach.

6.2.1 Indigenous research methodologies

At a broad level, my research incorporates an indigenous inquiry about knowledge connected to a phenomenon occurring within an indigenous gathering and meeting place. The goal of this research is to contribute to indigenous discourse about the role and use of culturally-loaded places for indigenous wellbeing in urban contexts. Hence, my methodological considerations are not limited to an inquiry about indigenous knowledge connected to wellbeing, but also need to encompass multi-level engagement in a sociocultural place of the indigenous group (see Section 6.3.1). I argue that these multiple factors make employing an indigenous methodology a necessity. This approach also contributes to a greater sense of cultural safety for all study participants while obtaining and analysing their unique insights and concerns. Indigenous scholars confirm that the relevancy of an indigenous approach is that it recognises and acknowledges the importance of indigenous peoples' worldviews, ethics and protocols as well as their historical, political, and socioeconomic contexts (Porsanger, 2004; Sherwood, 2010; L. Smith, 2012). Sherwood (2010, p. 128) contends indigenous research methodologies are also connected to indigenous people's survival, because "[they] provide valid and reliable data explicit of Indigenous people's perspectives providing the critical outcomes to remediate the consequences of colonisation". This contention is significant to my research which at a secondary level seeks to determine the effects of colonisation and consequent urbanisation processes on the cultural efficacy of Māori. A critical aim connected to my research outcomes will be the recognition of the increasingly significant role of urban marae as a vital support for developing cultural efficacy and [re]affirmation of its ongoing role as a site of Māori wellbeing.

Indigenous research methodologies work to ensure that research regarding indigenous issues is carried out in a respectful, ethical, correct and beneficial manner, as seen from the point of view of indigenous peoples (Kelley, Belcourt-Dittloff, Belcourt, & Belcourt, 2013; Porsanger, 2004; Snow et al., 2015). These methodologies have developed and been increasingly applied to indigenous peoples' circumstances in direct response to the concerns of the effect of Western research and the use of

Western research methodologies (Kite & Davy, 2015; Kovach, 2010; Sherwood, 2010; L. Smith, 2012). In the report of their study on quality of life for Aboriginal and Torres Strait Island populations, Kite and Davey (2015) agree with Māori academic Linda Smith's observation of Western research as 'unrelenting research of a profoundly exploitative nature'. These Aboriginal and Torres Strait Islander researchers have developed methodologies applicable to their own people. Indigenous scholars make it clear indigenous methodologies are not a subset of dominant Western methodologies (Sherwood, 2010; L. Smith, 2012). Rather, they offer a counterpoint to Western methodologies in a culturally appropriate and responsive approach suited to the particular researched indigenous community, to generate further indigenous knowledge. Absolon (2008, p. 272) provides a succinct definition of this methodological approach which emphasises its applicability and practicality to my research:

> Indigenous methodologies are holistic and rooted in Indigenous worldviews, paradigms, principles, experiences, and histories. They reflect the ideals and means by which conscious Indigenous searchers manifest their research agendas. These methodologies, when employed, move theory into practice, rhetoric into action, and visions into reality. They are examples of walking the talk.

Thus, embedded in indigenous methodological approaches are epistemologies and ontologies that are crucial in a research inquiry involving indigenous communities. It is also important to understand that indigenous epistemologies embody cultural values, beliefs and relationships that can vary between and within indigenous communities. Simonds (2013, p. 2190) reiterates this point and advises caution: "Indigenous knowledge, theories and methods cannot be applied indiscriminately across tribal nations, as there is great diversity among tribes". In consideration of these factors, a grounded understanding of indigenous epistemologies is essential (Absolon, 2008; Kovach, 2015; Porsanger, 2004). Kovach (2015, p. 57) explains further:

> Indigenous knowledge systems are the heartbeat of Indigenous methodologies. If only one understanding is to be garnered about indigenous methodologies, it must be this. It is not possible to engage in Indigenous methodologies without a foundational understanding of Indigenous knowledge systems. Indigenous knowledges are not Western knowledges; Indigenous knowledges are not built on Western thought.

Kovach adds that a comprehensive understanding of indigenous knowledge moves beyond identity alone. These points raised by Kovach contribute to the current debate regarding the validity or appropriateness of indigenous research conducted by non-indigenous researchers (J. Allen, Mohatt, Markstrom, Byers, & Novins, 2012; Aveling, 2013; Kelly et al., 2012). Although, it is not my intention to enter into this debate, I concur with Aveling (2013) who argues that undertaking research within indigenous contexts is difficult for non-indigenous researchers and they should not undertake it on their own. Her argument is based on a personal recognition of her lack of understanding of indigenous epistemology and experiences under colonialism. These considerations underpin another essential motivation for my choice to employ an indigenous methodology.

Principally, I am a Māori researcher (see Section 6.3.3) undertaking research involving both my tribe and wider cultural group, on my marae and the marae of other tribes. I am firmly grounded in my Māori identity and my subjective knowledge and experiences of being Māori. Hence, I determined very early in the development of this study that I would incorporate an indigenous research approach. This decision was influenced by my positioning as a Māori researcher and my previous research experiences involving a 'taxonomy of Māori research' (see further Cunningham, 2000). Indeed, I have partaken in research along a continuum ranging from not involving Māori (as participants), to involving Māori (as participants), to Māori-centred research and kaupapa Māori research. Due to the intense and multi-level engagement of both Māori people and marae, I believe the kaupapa Māori research approach to be the most effective and valid for this study. I agree with indigenous academics who emphasise that indigenous researchers position themselves within their studies and therefore draw upon their own indigeneity to use methods and understandings that are representative of their ways of knowing and being (Kite & Davy, 2015; S. Wilson, 2008). The methods associated with indigenous research must preserve unique indigenous voices, build resistance to dominant discourses, and, perhaps most importantly, strengthen the community. From this privileged position within the research, Porsanger (2004) argues that researchers must think critically about their processes and the effect of the outcomes on their own community. It is therefore in consideration of Māori and marae communities that I have chosen the kaupapa Māori research approach.

6.2.1 Kaupapa Māori research approach

Kaupapa Māori research is built upon specific Māori ways of being, knowing and doing and is connected to a general worldview. This research approach provides a framework or methodology for thinking about and undertaking research by Māori, with Māori, for the benefit of Māori (Berryman, SooHoo, Orange, & Nevin, 2013; L. Smith, 2012). This methodology has been developed and applied to numerous Māori-specific issues in response to the need for Māori voices to be heard (F. Cram, 2001; G. Smith, 1997; L. Smith, 1999). Kaupapa Māori research encompasses theory and methods. As Graham Smith (2012, p. 11) explains further, "Kaupapa Māori theory provides a space for thinking and researching differently, to centre Māori interests and desires, and to speak back to the dominant existing theories". The employment of this research approach has been integral to my aim of exploring Māori perspectives of marae garden participation. By employing a kaupapa Māori approach in my theory and methods, I was constantly reminded and prompted that I am in a privileged position when I am welcomed onto marae and in my conversations with Māori respondents when they share insights into their worldview and current realities. This placed on me an onus or obligation to engage with marae and all interested parties in a culturally appropriate way (see further Section 6.3.1) and further that I establish a commitment to them (personal and culturally) that the information they shared would be respected as taonga (treasure) and used for their benefit. A central premise of the kaupapa Māori approach is that Māori research must be undertaken for Māori gains. As Berryman (2013, p. 9) claims, "Locating research within Māori cultural perspectives is essential for ensuring positive outcomes and benefits to Māori". It situates research within Māori aspirations, preferences and aspirations. Upon

commencing this research I understood my commitment to all of the marae that the knowledge they shared would be of benefit to their marae.

As I mentioned in the preceding section, this research approach is broad, organic and adaptable. This feature was beneficial to my research for two reasons. First, I need to be clear that my selection and application of cultural efficacy theory was not fully determined until the majority of my interviews had been completed. This meant the research design and subsequent interview procedures were not influenced by a theoretical framework and so the interview methods remained fully organic during data collection (see further Section 6.4.3). For example, my interview questions asked respondents for broad descriptions of their garden participation, and there was no pre-defined direction of answers required. This resulted in descriptions of their gardens based on what the participants determined was important. While undertaking interviews without guiding questions to predetermine the direction of the conversation could be viewed as providing benefits in terms of insights gained through collecting varied and spontaneous responses, it also presented a challenge and lessons learnt. At the completion of the interviews when I was analysing the data, I found that cultural capacity or efficacy within marae was not consistently or richly discussed by several respondents. As a result, my findings chapters include discussion of why central capacity themes were not discussed or deemed noteworthy by the respondents. Notwithstanding, the second benefit of an adaptable research approach was the interview settings and the variable nature of the marae and the gardeners. Interviews were undertaken in various locations on marae (i.e. kitchen, meeting house and gardens) with an at times undetermined and changing number of interviewees. The benefit of these open interviews was that other gardeners passing by were frequently prompted by my respondents to further elucidate on their descriptions or perspectives connected to the gardens. In addition, I was able to create a backup pool of potential respondents to call on if my any of my confirmed respondent group became unavailable. Overall, this research approach enabled my research processes to develop within reasonable boundaries, while ensuring that research questions and contentions could be addressed. Although, this could be viewed as taking advantage of the broad parameters of kaupapa Māori approaches, I found this flexibility invaluable in the data collection phase of my study.

In justifying the application of this research methodology, it is equally important to acknowledge my main point of departure from kaupapa Māori research. This divergence is in respect to current discourse on indigenous methodologies that insists research must originate within communities or incorporate partnerships. Indigenous researchers contend that the involvement of indigenous peoples in all aspects of research projects is conducive to successful studies (Kelley et al., 2013; Kelly et al., 2012). Involving the community in all research phases is seen as making a strong contribution to building research capacity. Kelly (2012, p. 1) addresses this point:

> Building research capacity means not simply equipping local people to undertake research on a particular project, but to have the knowledge and skills to undertake research in other areas. It should also provide people with a critical understanding of the difference between empowering and disempowering research.

Multi-level involvement is integral to kaupapa Māori research for the same reasons. This includes the active involvement of the community in framing the initial objectives and purpose (the kaupapa) of the research prior to the commencement of a project (S. Walker, Eketone, & Gibbs, 2006). However, while this study was developed in response to a review of food gardens on urban marae, it was not conceptualised through collaboration or in partnership with any marae or Māori communities. The research was not prompted or requested by the marae communities themselves and, although support was sought from the participating marae, the research design and its implementation were largely conceived within academia. I agree that past experience shows there is significant value in research that is instigated and situated within Māori communities. Indeed, when Māori communities initiate their own research projects, they are more likely to be relevant and applicable to their community needs. I acknowledge the importance of collaborative researcher-community partnerships – but to be clear, this research was not. While I endeavoured to ensure the research was collaborative I faced many challenges within the marae communities. My intention was to involve my respondents at all stages of data collection, discussion and analysis, however this became problematic due to the transient nature of the respondents. In addition, the availability of many of the marae and their members was limited due to other commitments and the workings of urban marae. Granted that the central aim of my research was to gain an understanding of the development of cultural capacity for Māori on marae, it would have been ideal to build research capacity for marae alongside my research investigation. Nonetheless, while I was not able to achieve multi-level involvement in this study, I intend to accomplish this outcome in any future research I undertake.

6.2.2 Qualitative Methods

The research approach for this study incorporated qualitative research techniques underpinned by a kaupapa Māori research approach. A qualitative or interpretative approach focuses on understandings of the world from the study respondents' point of view (Denzin & Lincoln, 2011). This requires drawing meaning on aspects of the world from the personal perspectives of participants, not the researcher (J. Green & Thorogood, 2009). Qualitative methods and kaupapa Māori research fit well together since they both emphasise the importance of Māori knowledge gained from discussions of real life experiences (Jones, Ingham, Cram, Dean, & Davies, 2013; Moyle, 2014). Narrative interviews, focus groups and in-depth individual interviews which are the data collection tools of qualitative research enable Māori realities and perspectives on phenomena to be heard (Ngā Pae o te Māramatanga, 2012; Pihama et al., 2002). Applying a qualitative methodology to indigenous wellbeing research also has benefits because health behaviours often involve complex human interactions and issues that can rarely be studied or explained in simple or quantifiable terms. As Green and Thorogood (2009, p. 25) argue, "Without an empathetic understanding of why people behave as they do, we are unlikely to identify the possibilities for change". This approach is important to my methodological framework because it facilitates an exploration of complex and dynamic situations and issues for indigenous people, such as the meanings Māori participants experience in their gardens.

Many of the connections between marae community gardens and wellbeing are via intermediate socio-environmental pathways which require understandings of multiple meanings and are difficult to

quantify, thus making qualitative methods the most appropriate approach. Further to this, qualitative research does not just report on the experiences of the participants, but also analyses them in an effort to produce research data that have some value beyond reproducing anecdotes, or colourful examples (J. Green & Thorogood, 2009). Many health promotion studies within indigenous communities have been overly preoccupied with quantitative assessments of improved health, based on personal results of individualised health programmes (refer Chapter 3). I suggest that a cultural-collective approach serves to prioritise building the cultural capacity needed for increasing Māori health autonomy and improving wellbeing. Hence, how Māori feel this can 'be done' or 'is done' can be best understood and facilitated by a qualitative approach. Subjective and context-bound experiences, in this case of Māori sociocultural factors and health, can be comprehensively explored through an interpretive framework. Later, in Section 6.4.3, I describe the practical application of this research method in the interview processes with the respondents.

6.2.3 Cultural efficacy theory

The theoretical framework for my research approach is cultural efficacy theory (refer Chapter 2). After lengthy deliberation, this framework was selected as the most applicable for gathering and examining the results of indigenous peoples' participation in a health activity based within culturally-loaded places. As I mentioned earlier in this section, my selection of this framework was not finalised until I had nearly completed all of my interviews. Driving my framework search was the intention to review and understand the role of culturally-loaded places, such as marae, in wellbeing outcomes for indigenous peoples within urban contexts; specifically, the influence of cultural-collective factors that are sourced from specific urban environmental contexts. Very early in my framework search, I was led by the simplistic notion that marae in cities are unique cultural places that provide rich sources for wellbeing. This notion was based on my own bias regarding urban marae and my current connection to my own urban marae (see further Section 6.3.4). It became apparent after some time spent reviewing frameworks that the main constructs: indigenous peoples, places and wellbeing – and their interactions – were significant to my study. Indeed, specific indigenous sociocultural places (and the people within) are loci of support for health, and behaviours learnt or shared within these places can be linked to wellbeing. After many discussions with my supervisor, I then decided to concentrate on frameworks that could provide understandings of marae as physical urban places that enable Māori to build and increase their cultural efficacy, including capacity and confidence. In other words, increasing cultural capacity for indigenous people affects wellbeing and specific indigenous places are both an important source of cultural efficacy and provide a supportive environment to enable this to more easily occur. This narrowing of direction eventually led to cultural efficacy theory, which is built on the notion that increased cultural-collective group ability can lead to behavioural change and wellbeing (refer to Chapter 2). While Bandura's framework applies to individual and collective factors in the development of efficacy beliefs, in this study, as previously argued, I argue these frameworks can and should be extended to include sociocultural factors as influences for indigenous peoples' holistic wellbeing.

Hence, cultural efficacy theory provides a framework for understanding the interactions between indigenous peoples, their behaviours and sociocultural environments as rich and inspirational sources for behaviour change (see Chapter 2). Importantly, this framework not only provides a lens for understanding the importance of cultural-collective experiences as preconditions to wellbeing, but also emphasises the role of culturally-loaded places. This recognition of the significance of the relational factors connected to increased cultural efficacy and capacity guided my literature review, methodology, research processes and data analysis. My utilisation of this framework in a qualitative study differs from the recent work of Houkamau et al. (2011) where Māori participants completed an identity and culture questionnaire based on six dimensions of Māori cultural engagement the results were linked with cultural efficacy and outcomes relating to subjective wellbeing. In my study, I did not consider measuring cultural efficacy based on a predetermined scale because it would not gather the intricate idiosyncrasies of peoples' sociocultural experiences and their cultural environment. Also, the self-beliefs of people within a cultural group and their collective abilities cannot be quantified in numbers or measures. As Penetito (2011) argues, Māori are diverse and it is a fallacy to research Māori as a homogeneous entity, and to pigeonhole ways of being as Māori. I am reluctant to add any further contribution to categorisations of what is, and is not, 'being Māori', or to suggest a checklist. In this study I have not utilised cultural efficacy theory to measure efficacy, but instead in a discussion of how the relationships between people, cultural factors and places contribute to raising efficacy.

6.3 Ethical considerations

In this section I discuss the ethical dimensions of this research including my positionality, and the study's limitations. Research with and within indigenous communities encompasses many ethical complexities that must be carefully considered before engaging in the research activities (Snow et al., 2015). I outline my engagement and consequent relationships with the study marae as research sites. Each marae required different encounters of negotiation and consultation before, during and after the research interviews. I argue that my marae relationships were an integral component of this research, because they created an ease of access to both the gardeners and their gardens. I learnt crucial lessons in maintaining effective marae relationships during this study that will impact my future research endeavours.

6.3.1 Ethics of kaupapa Māori research

Kaupapa Māori research incorporates guidelines emphasising culturally relevant processes and practices that can assist researchers to carry out ethical, culturally competent and mutually beneficial research. As Māori academic Smith (2014) argues, the responsibility of ensuring ethical values, practices and expectations are applied and negotiated throughout the research process falls squarely on the shoulders of researchers. I shared this responsibility with my research advisors, including my kaumātua advisor. Ethical procedures were determined and guided entry, interviews and exit from

each marae. I also consulted the *Rangahau*[18] website which was created by Māori academics and provides in-depth advice regarding the ethical considerations of kaupapa Māori research within Māori communities. Engaging with Māori communities for research requires a process of relationship building and is integral to a kaupapa Māori approach. Ethical research concerns regarding Māori revolve around respect for their rights, control over research processes, and reciprocity within research relationships (F. Cram et al., 2004; Jackson, 2015; L. Smith, 2012). These factors ensure that equitable benefits are realised. Thus, ethical research with Māori needs to include cultural processes and preferred tools that observe specific Māori principles, practices, and processes. Knowledge of cultural protocols (tikanga), cultural values and traditions ensures a respectful connection and rapport with Māori research participants. Tikanga Māori provides both an ethical foundation and practical guide for entering Māori communities, giving specific guidance on how things ought to be done, and also encompassing a wider philosophical value and belief system (Hudson, Milne, Reynolds, Russell, & Smith, 2010; H. M. Mead, 2003).

In brief, tikanga can be seen as a rigid set of rules that guide actions, but it can also incorporate flexibility depending on the context and situation. Locally specific Māori protocols are considered tikanga, and its application in research aims to enhance relationships and ensure the preservation of mana (justice and equity, reflected through power and authority) (Hudson et al., 2010). For example, whakatau (welcome ceremony), hui (gatherings), mihimihi (greetings) and whakawhanaungatanga (relationship building) can assist with laying the groundwork for research interviews. In this study, all of my interviews commenced with mihimihi, whereby we disclosed our tribal affiliations and I also included a brief explanation of the study. I concur with indigenous researchers who contend that when researchers identify themselves in terms of who they are and where they are from[19], it helps build transparency and trust between all parties (Lavallée, 2009; Marsh, Cote-Meek, Toulouse, Najavits, & Young, 2015). The use of mihimihi serves to establish connections between researcher and participant prior to vital information being shared. During one interview, the mihimihi process revealed that the respondent belonged to my tribal group. The acknowledgement of this mutual link resulted in the subsequent establishing of a relationship that has lasted beyond this study. Personally, I see this process of mihimihi and whakawhanaungatanga as a hugely beneficial outcome of kaupapa Māori research.

6.3.2 Ethical marae relationships: features of trust, consultation and obligation

A distinct feature of this research was the multi-level involvement by marae[20]. Urban marae were the research subject matter, the source of the respondents, the site of many of the interviews, and a crucial recipient of the research findings and outcomes. Due to the significant involvement of marae, I dedicated the first phase of this study to recruitment of marae and establishing of relationships before commencing interviewing. As Kovach (2010) argues, indigenous methodologies include interpersonal

18 www.rangahau.co.nz
19 i.e. Ancestors
20 I refer to and discuss marae in this section not only as the physical site and buildings, but also the marae committee members, other family and marae members.

and relational groundwork (i.e. participation in ceremony, visiting community), alongside Western traditions of reviewing literature and decisions about design. Establishing relationships with each study marae was an important aspect of this research. During this pre-recruitment phase, I met with several marae managers and gauged their interest in my research topic. I also revisited marae with which I had pre-existing research relationships. I did not fully proceed with a formal request to enter a research relationship until I was confident with the study's applicability for each marae. The conduct of the study was subject to the collective authority of the marae community and the tikanga of the marae, which needed to be fully taken into account alongside university defined ethics. Hence, much consideration was given in the research design to the processes of selecting and engaging with each marae, and providing useful and relevant information on the complete nature of the research. From my experiences as both a current marae member and a researcher (see further Section 6.3.3), I was mindful that marae relationships had to be mutually beneficial, open and unobtrusive. The study took place over four years and relationships with each marae had to be established prior to the interviews commencing, and then maintained during and after the interviews took place. Indigenous research is about building and maintaining trust, and ensuring that the research relationship is reciprocal (Chilisa, 2012; Hart, 2010). I did not take my engagement and obligations lightly, and sought advice and guidance from within my project team, my own marae and kaumātua advisor regarding how to establish and maintain an ethical and respectful relationship with the marae. I understood I would be accountable for the research processes and outcomes. These factors were central to this research.

Obtaining the trust and confidence of each marae allowed ease of access to the marae, the gardens and the gardeners. Making time to build trust and understanding is considered critical to research relationships, and includes making connections and building rapport between the participants and researchers (Chilisa, 2012; Laycock, Walker, Harrison, & Brands, 2011). I was aware that many marae have a distrust of research projects and their actual benefits their communities. To build trust, I was open to sharing all study information with the marae and presenting in any forum deemed necessary. I was very clear about this research being my PhD study and a health research project, and that the findings and outcomes would be shared back to each marae – verbally and in written form. In my first approach to marae committees, I provided written information and then requested an opportunity to make a PowerPoint presentation in person. Each marae was provided with an ethics approved letter introducing the study (see Appendix A). Marae were given time to review the information letter and ask questions, either via email or at the oral presentation. Of the eight marae approached, five requested I make a presentation to their committees and three requested a one-on-one meeting with the respective marae managers. At the presentations and meetings I was open about my intentions and the implications of their involvement in the study. I also addressed any queries or concerns they had at this time. I was fortunate that all the marae I approached were willing to participate and none had any concerns or issues connected to the proposed research. At this point, I obtained the verbal and written consent of each marae to proceed with the study.

Processes of open consultation were integral to building and maintaining the trust of each marae. As mentioned previously, I shared all study information and addressed any concerns raised by the marae in the course of the research. Each marae community was unique, and there is no 'how to' list of rules

or checks for working with Māori and maintaining consultation for effective and appropriate research relationships. In this study, I ensured I built good relationships based on ongoing consultation and face-to-face contact with the marae committees, marae managers and the respondents whenever possible. I sent regular pānui (newsletters) to each marae with updates about the research, and visited marae in person to keep in touch and discuss progress. I maintained a diary of my physical and verbal interactions with each marae to ensure that I wasn't over researching any marae, or becoming a pest. During the recruitment phase, a respondent from one marae expressed that she felt her marae was over-researched and that researchers were nearly tripping over each. Once I had received approval from her marae committee to proceed with my research, I too encountered other researchers on the marae and therefore endeavoured to be as unobtrusive as possible. By maintaining open contact and consultation with the marae and their respondents, I felt I achieved a relationship of trust with the marae and gardeners.

For me, one of the most important considerations in establishing and maintaining research relationships with the study marae were my ethical obligations. All researchers face an array of ethical requirements associated with obligations to their research participants. Yet, when indigenous researchers are interviewing their own people about conditions specific to their everyday lives I argue that such obligations significantly increase and become more personalised. Māori academic Erana Cooper (2012, p. 42) succinctly describes the complex responsibilities for Māori researchers:

> Māori expectations of Māori researchers, in terms of cultural accountabilities and directly applicable outcomes, can be extremely high. Māori audiences may expect that Māori researchers will deliver results which will contribute to improvements in Māori health, educational, employment, social and economic status in ways which those audiences can both understand and adopt. Consequently, Māori researchers are often simultaneously subject to both academic and Māori cultural accountabilities, each of which rightly exerts its own influence upon the nature of the research work.

In undertaking this research with marae and their gardeners I assumed obligations which I consider to be my biggest responsibility and which hold me intensely accountable to my study marae. I concur with Marsh (2015, p. 5) who contends that indigenous researchers take on-board a relational accountability: "[Researchers are] not only responsible for nurturing and maintaining relationships, he or she is also responsible for everything and everyone that is connected to the research process". This study involves the wellbeing of my Māori community, my tribe and my family. It is relational and personal, and comes with obligations and accountability that my research intentions are ethical and beneficial. I am obligated to maintain and nurture open, reciprocal and respectful relationships. I am also conscious that I have entered into a relationship with marae that is primarily dictated by their needs and my research is not their priority. By gaining marae consent I was effectively being entrusted to interview their members and produce research that would have benefit for them. It was also a mutual agreement to a relationship that extends beyond the completion date of the research. As Pihama (2011, p. 53) argues, "[I]t's about forging really strong relationships that are lifelong. They're not partnerships that you walk into and out of sometime down the track when you don't require that

partnership any more or we're separated or the contract finished or whatever. That's not how it works". In this regard, my obligations don't finish at the end of this research; I have created links with marae that will last beyond this study.

In terms of accountability, I have a responsibility to the data my respondents have shared. Researchers agree that indigenous participants and communities are stewards of their data and researchers may only borrow it for specific and agreed use (L. Smith, 2012; Snow et al., 2015). Hence, giving back any work I produced to the marae was essential and this process is ongoing. During the follow-up interviews (see Section 6.4.3) and in discussions of my preliminary findings, several respondents expressed interest in how their data would be utilised. Questions were raised about the implementation of findings and the potential target audiences for the research reportage. One respondent wanted this research to be shared with non-Māori as well as other marae. Another respondent Wyn summarised the importance of this research for their gardening group and marae (Interview, Group Follow-up, Nga Whare Waatea Marae, 26 September 2013):

> It's about us as Māori observing our culture and our traditions …. So we have seen a different variety of what's happening at different marae, core things that are a bit similar, the struggle is quite similar across all marae as well, because in your kōrero (statement) you were talking about how to make gardens sustainable beyond the funding. All the marae have that worry and that challenge, and I wish we could bring back the experiences from other marae, but they don't know yet either, but it would be good to be a part of a process when we call talk about the process, and talk about then how do we do this.

Wyn's reflections serve to remind me of the importance of my research for all marae and the need to ensure the results are shared widely. While over the few years since the commencement of this study some relationships with marae have weakened due to changes occurring on the marae and many respondents no longer attend their marae or gardens, I remain committed to my obligations and accountabilities.

6.3.3 Ethical procedures

The main ethical principles for this research rest on informed consent, anonymity and confidentiality, voluntary participation, and protection from harm. Ethical approval from The University of Auckland's Human Research Ethics Committee was gained prior to the commencement of this study in August 2011 (see Appendix G). All the ethics documentation prepared for the respondents and marae participating in this study comprised both an English and Māori version. Informed consent was required and obtained not only from individual respondents, but also for the marae as the research group and site. Once consent had been obtained from the marae, potential interviewees, identified with the assistance of marae, were presented with a participant information sheet explaining the nature of the research (see Appendix B). Each interviewee completed and signed a consent form which provided them with (de)select options with regard to confidentially, the publication and sharing

of their information and use of Te Reo. Confidentiality in terms of naming or not naming respondents has several ethical implications for any research, and presents a particular dilemma for Māori research in protecting anonymity while at the same time honouring and identifying the source of the shared information. To address this issue, my respondents were provided with the option of remaining anonymous or being identified by name, or a chosen name. The majority of my study respondents elected to be identified by their own names. Interestingly, during preliminary findings meeting one of the respondents recognised that I had used her quote and specifically requested that I attach her name forthwith. She told me later that she was proud of what she had said and wanted to be identified as the source. Another issue that arose regarding confidentially was the need to protect the integrity of the study marae alongside other marae members who might be named or discussed by respondents. To protect and respect the study marae and other marae members, any comments that were directly or indirectly deprecating were not utilised in the analysis. Fortunately, nothing was said that could potentially hurt, harm or offend any of the interested research parties. Any named reference to a non-respondent in a selected quote was substituted with “XXX’ to protect their anonymity.

All of my respondents were offered the option of having a team member who is fluent in Māori conduct their interviews in the Māori language. My understanding of Te Reo is at a basic level, hence I arranged the support of fluent speakers, team members and kaumātua if required. However none of the respondents chose to be interviewed in Te Reo, which is perhaps reflective of the resounding loss of fluency among Māori. Respondents were advised that participation in this research was entirely voluntary and they would be given several opportunities to withdraw their information during the study. Two important ethical procedures specific to this research involving marae were factored into our ethics application due to their involvement as the research sites, and consequently received approval. First, marae had the right determine their withdrawal from this study as a research unit. This meant marae could withdraw themselves and all of the respondents from the marae from the study and none of the corresponding data could then be utilised. This proviso was developed to ensure a reciprocal and respectful relationship with marae by recognising their autonomy as research entities. Once the research process began, they had control of both the data and outcomes. The second ethics procedure involved the collection of photographs of the marae, gardens and gardeners. Approval was first obtained from each marae to take photos on and of their premises, and then individual approval sought from each respondent when they appeared in a photo. This procedure supported the intellectual property rights of the marae and ensured marae were photographed respectfully. In observance with Māori values and beliefs, marae are not merely buildings and land; they are living and breathing representations of tribal ancestors.

6.3.4 Positionality

In this section, I discuss my positionality within this study in an effort to provide an understanding of my worldview and any possible resulting biases in my research methodologies and findings (Snow et al., 2015; Watzlawik, 2012). Positionality refers to the position or location of a researcher within the research study, in particular in relation to the subject, the participants, and the research context and process (Savin-Baden & Major, 2013). Researchers concur that the privilege and obligations of

conducting research with indigenous peoples must extend to disclosing positionality (Dana-Sacco, 2010; Kovach, 2010). My personal lens has shaped this study of the development of cultural capacity on urban marae from conception to completion. Being Māori and self-identifying as an urban Māori shapes who I am and my personal attachment to this research. I was born in Rotorua and am a tribal member of two Bay of Plenty iwi, Ngāti Awa and Ngāti Rangiwewehi, but have mostly lived in the urban area of Tāmaki Makaurau. Over ten years ago I made a commitment to a personal development journey of learning about many aspects of my Māori culture. This commitment has influenced my engagement in my urban marae and my academic learning. All my studies and consequent employment and research have been Māori focused. As a latecomer to Māoritanga, I am keenly aware of the diversity within identifying as Māori, and variations in depth of knowledge among Māori in general, and also within my own family. Of my five siblings, only one is fluent in Te Reo with the remainder having varying levels of ability. Ironically, my father is a native fluent speaker and has an in-depth knowledge of Māoritanga. Since I made my commitment to becoming an active member of my urban marae while learning about Māori, I have developed a strong sense of identity and wellbeing from the acceptance of my marae family and this relationship has benefitted me both socially and emotionally. I feel at home on my marae. Yet, as I discuss in Chapter 1, and again later in Chapter 10, I know from my personal experiences within marae that they are not comforting or familiar environments for all Māori. It often seems to be the case that Māori need a minimum level of cultural capacity in order to enter the marae domain without feelings of discomfort or alienation. This requirement further supports the role of marae and the need for the increased development of cultural efficacy. As I argue later in Chapter 7, marae gardens provide an informal cultural-collective space for Māori to develop and increase their Māori and marae knowledge.

Nevertheless, I have developed a strong passion for the role of marae in Māori wellbeing and know from personal experience that they are underutilised and underfunded by both urban Māori and governmental bodies. Indeed, I am driven by my contention that the government continues to undervalue and underfund marae and their potential role as effective health sites. These perspectives and considerations have influenced my research, and set my personal lens. My research has been guided through my experiences as a participant-observer of my own and other marae, as well as by my personal understanding of the needs of urban marae. One of the study marae is my own, and three research respondents are my relatives. Two of these family members were known to me prior to this study, and one is a renewed connection as a result of this study. The value of these connections is in keeping me constantly mindful that my research is respectful and responsible, and above all there must be benefits for participants from sharing their personal information. Because I am a current member of one of the study marae, ideally the outcomes of this research should have very real and visible impacts on my own urban marae community. Overall, I have a personal, cultural and political investment in this study and I am neither detached nor covert about that investment.

In disclosing my positionality within this research I also address the ‘insider-outsider’ dichotomy prevalent in many aspects of this study, and the consequent implications for my methodological approach. These aspects are most evident in my engagement with marae and the interview methods. The main insider-outsider juxtapositions are tribal affiliation and non-tribal affiliation; and university

researcher and marae-based researcher. In this study, my being Māori and familiarity with urban marae communities allowed me to connect with respondents on a common cultural level. I was an insider as a Māori, but may have been considered an outsider when working with Māori from a different tribal area. Many of the respondents represented various and distinct tribes, and my own tribal affiliations and protocols differed from theirs. As a member of the researched group I was an insider who was also participating by contributing to meeting the needs of the community. As an outsider, I was an observer researcher with a specific research agenda not set by the community. Insider-outsider is an academic discourse that constructs difference by turning the researcher into the 'other', the outsider or stranger, in order to make comparisons between the researcher's culture and that of the culture being studied. It is commonly believed that indigenous researchers find it easier to enter the research field in their own communities because they have some familiarity with the language and customs of people of their own culture. Weiner-Levy (2012, p. 1153) challenges this notion, arguing that "factors such as empathy, knowledge, alienation, exclusion or inclusion, a sense of belonging to and understanding the participants' inner world – may be more important". She adds that her study within her own cultural group highlighted expectations of similarity, but in reality served to accentuate differences in lifestyles. Weiner-Levy (2012, p. 1164) contends that "being an integral part of the society one studies does not guarantee automatic entrance, trust or acceptance, especially because researchers are usually based outside their home communities, at times causing a sense of distance or discomfort". In Māori communities, a person may be deemed an outsider due to their affiliation with another iwi and marae. Further to this, while being Māori and identifying as Māori could be viewed as ensuring the researcher is seen an insider, this is not always the case and identifying as Māori may only be useful for entry into Māori contexts like marae. After that, an insider has the potential to become the outsider because they are not members of the marae and, in case of this research, not a gardener. In the context of this study, I am therefore both an 'insider' and an 'outsider', both a participant and observer.

Of note, this PhD research forms part of an HRC funded project. I am therefore in the privileged position of completing my PhD while working on a funded project. This means that I have worked within a project team who have assisted with many aspects of the research design and implementation, most importantly the establishing and maintaining of marae and participant relationships. An important aspect of being part of a research team is that I am able to constantly check and review my positionality, particularly in regard to obtaining critical feedback on my data and findings.

6.3.5 Methodology limitations

As with any research, there are a number of study limitations. One of the main limitations is the lack of representation of Māori gardeners over a larger sample of urban marae. Ideally, I would have liked a sample size of at least 12 twelve marae to provide a wider range of opinions from differing marae. However, the study criteria required that gardens be active at the time of the study, thus marae with inactive gardens were excluded. Their experiences, perspectives, and reflections may have been different from those held by my current gardeners. It is worth noting, however, that my sample did

represent a depth of opinion due to the mix of the respondent age, sex, garden participation, and garden size and purpose (see Table 3). The advantage of limiting my study to current and active gardens was that respondents' perspectives related to the current validity of their garden participation and did not include speculative about what happened in the past, or what might happen in the future. A related limitation was the marae and Māori autonomy strongly evident in my observations of marae and their gardens and the conversations of the gardeners. The notion and practice of autonomy were clearly apparent within my smaller sample size. Although I have explored autonomy throughout my discussion chapters, I recognise the exciting potential to explore this concept further within a future research study (see Chapter 10). In light of this limitation, I intend to incorporate a deeper and richer study of the tangible and intangible aspects of urban marae autonomy and wellbeing in my future research.

A further limitation of my study is connected to a series of circumstances that may have affected my study findings and results as a consequence of my study being situated within a larger HRC project, and the ensuing late selection of my theoretical framework. I address the influence of meeting HRC timelines and outputs throughout this chapter in acknowledging that these wider project responsibilities superseded my own research timelines for selecting conceptual frameworks, reviewing the corresponding literature, and then proceeding with interviewing and analysis. As I have mentioned elsewhere, had my selection of the frameworks been finalised prior to interviewing, my interview questions and data may have captured more in-depth conversations about the role of marae and Māori culture in their participation. However, this is speculative and not directing the interviews to address a selective and predetermined direction meant my data was largely un-coerced. The last research method limitation is related to data analysis in that the interpretation and meaning making of this research was inherently framed within my own subjectivity. While I have worked to be as reflexive as possible within this research by firmly locating myself and providing the context of my own experiences and perspectives, my own perspectives may have coloured the interpretation of the results as researchers are not immune to the influence of their emotions and personal points of view. Thus, my research results represent my qualitative analysis and could be subject to other interpretations. To help address this issue, I regularly conferred with my supervisor and team members about my research progress and was constantly reminded of my own biases and their effects on my findings. My potential bias in supporting both the role of marae and gardens could have impacted which aspects of their garden participation respondents chose to share. It is also possible that some respondents may have felt that I was representing the interests of health systems and potential funding bodies. In addition, in connecting with my respondents as a fellow Māori and urban marae member, I may have established a common link that created a space to openly share information for some gardeners but not for others. For example, some respondents many have felt less compelled to explain in-depth their attachment and participation in their urban marae and gardens to a fellow Māori and marae member. While I cannot be sure of the exact results and effects of insider and outsider influences, I concede they may have created some limitations in the interviewing and data collected.

6.4 Methods

I next describe the methods used to obtain the respondents' data. I have included retrospective reflections on the application of the research methods, including events and issues encountered when conducting the research. While theorising how to conduct and implement research involving Māori is vital, the reality and practical application often differs due to several factors. I paid careful attention to the research methods knowing that each marae setting would be unique, dynamic, and complex. An important consideration is the effect of the larger Health Research Council (HRC) project on this research. Time constraints, the requirement to produce HRC dictated outputs and the associated divided responsibilities affected many aspects of my research including the order and speed of research activities and processes. In the following sections I will identify specific examples of the effect of the wider project on this research, while outlining the research setting, respondents, and methods of data collection.

6.4.1 Marae setting and garden sites

Figure 8: Case study marae

Top marae – (L-R) Manurewa, Mataatua and Ngā Whare Waatea
Middle marae – (L-R) Te Puea and Ruapotaka
Bottom marae – (L-R) Makaurau, Ōrākei and Papatūānuku Kōkiri

Tāmaki Makaurau was identified as the ideal region for this research because it has the largest number of urban Māori of any region in New Zealand. To recap from my preceding chapter, approximately 30,000 Māori live in the Auckland City region, comprising 7.8% of Auckland City's total population (Statistics New Zealand, 2006c, 2011). The pre-requisite for inclusion was having an active food garden on the marae grounds. To providing a sample of marae situated within a high population

density area, marae with food gardens were selected from all marae within a 30km radius of the central Auckland metropolitan area. A directory maintained by Te Puni Kōkiri (TPK) listed 75 marae within the greater Auckland region (Te Puni Kōkiri, 2010). Of this number, 30 marae were deemed eligible, 14 of which were funded by TPK as part of the Maara Kai programme (refer to Chapter 5). I obtained support from TPK during the pre-recruitment phase of this research, since the study would potentially include marae that had obtained their funding. However, as the recruitment phase revealed, very few of the marae had solely accessed TPK (see Chapter 1) funding. Once eligible marae were selected, I sought ethical approval and consent to undertake the research. I then commenced this research with the eight marae detailed in Table 1.

Marae name	Iwi affiliation	Land area & garden type	Study participants
Manurewa	Pan-tribal/Urban	16,141 square metres - Horticultural teaching gardens	6
Makaurau	Mana whenua	6,169 square metres - Community planter beds, native seeding nursery	7
Ngā Whare Waatea	Pan-tribal/Urban	45, 977 square metres - Vegetable garden beds	5
Papatūānuku Kōkiri	Pan-tribal/Urban	29,795 square metres – Large community tended garden beds	5
Ōrākei	Mana whenua	25,102 square metres - Community garden beds, Auckland City Mission garden, native nursery	7
Mataatua	Taura here	7,390 square metres - Kōhanga reo garden boxes	1
Te Puea Memorial	Pan-tribal/Urban	29,783 square metres - Garden beds	1
Ruapotaka	Pan-tribal/Urban	2,171 square metres - Garden beds	5

Table 2 Total case study marae snapshot

KEY
Pan-tribal/Urban – marae not affiliate to specific iwi Taura here - marae affiliated to a iwi from another area Mana whenua – marae affiliated to iwi of this area

The marae gardens included in this research varied in terms of the gardeners, length of time established, produce and reason for creation. All of the sites included in this study met the basic criteria of being active community gardens attended by Māori.

6.4.2 Marae respondents

During the pre-recruitment phase of this research, marae visits were conducted to view the gardens, establish an understanding of their size and context, and to gauge the number of participants actively involved in each garden. Upon selection and consent from each marae, the marae managers then dictated the method for inviting participation, either directly through them, or with their assistance in arranging a meeting. The original goal of this study was to interview five gardeners per marae in an effort obtain a workable and reasonable variety of perspectives within each marae, and a total research pool of approximately 40 respondents. This would provide qualitative samples large enough to reveal important and varied perspectives, but at the same time not so large that the data becomes repetitive, and eventually unnecessary. When writing the research design, I had naively or

optimistically presumed that each garden would have at least five gardeners involved in their creation and current maintenance. This was not the case, and during my pre-recruitment phase (refer Section 6.3.3), I was able to ascertain that the gardeners varied in number from one to seven per garden. At this stage, I adapted the research design to be flexible regarding the number interviews, in accordance with the number of gardeners actively participating at the time of the research. I also decided not to interview more than eight respondents from one site, because the data amassed could potentially be unmanageable or reach saturation in terms of topics discussed. At the completion of the interview phase, 34 respondents consented to participate in this research (see Table 3). Securing and undertaking the interviews often proved difficult, largely due to the transient nature of both the gardens and gardeners. One of the respondents commented on the number of gardeners on their marae, and noted the gardeners were as seasonal as the garden itself – always changing. All marae garden members who were approached to be interviewed consented to participate.

All the respondents were over 16 years of age, with the exception of one respondent who was 15 at the time of her interview. The main recruitment criteria for this study were that each respondent be an active marae gardener and self-identify as Māori. These criteria were set to ensure that the study generated findings that would be both useful and responsive to Māori needs and issues. Interestingly, and largely by chance or because the gardens were on marae, all the respondents contacted and approached were Māori. During the recruitment phase, I did not ask any respondent if they self-identified as Māori in terms of Māori protocols and personal beliefs as I deemed this to be discourteous. Nonetheless, prior to their interviews, all respondents were provided with information sheets (refer Appendix A) that stipulated both the intentions of the research regarding outcomes for Māori, and the study requirements (i.e. Māori gardeners). At this stage it was clear that I required Māori perspectives regarding marae gardens. Although my recruitment criteria required that respondents self-identify as Māori, I did not intentionally exclude non-Māori from any of the interviews. As many of the interviews were conducted on marae and around the gardens, the interview settings were open spaces where I could not, and did not, exclude other gardeners contributing opinions, including non-Māori. However, the processes of securing interview times with the Māori respondents first, and then the location, ensured that the main interviewee during every interview met my recruitment criteria. As it transpired, there were very few non-Māori present at the time of the interviews, and none of this small number offered an opinion on the current topic matter.

None of the respondents spoke Māori fluently during the interviews, although Māori terminology was used extensively. Māori protocols were observed for the majority of interviews, with mihimihi to start the proceedings before gardening discussions took place. I took cues from participants as to whether they wanted to observe formal or informal cultural protocols. The more formal protocols were largely conducted by my team member who was male and knowledgeable in Māori protocols. A small number of participants were active only in the establishment of a garden, and not its everyday maintenance. Three of the research participants had been employed to manage the marae, or specifically the gardens, and the remainder were volunteer gardeners. The total participant group comprised of marae members who gardened, and gardeners who did not belong or participate in the marae where their garden was situated. The composition of my research respondents are noted in the table below:

Marae name	Sex	Age	Role	Interview	Interview venue
Manurewa	Wahine	Pakeke	Student gardener	Group	Marae
	Tane	Pakeke	Student gardener	Group	Marae
	Tane	Koroua	Student gardener	Group	Marae
	Tane	Koroua	Student gardener	Group	Marae
	Tane	Pakeke	Student gardener	Group	Marae
	Tane	Taiohi	Student gardener	Group	Marae
Makaurau	Wahine	Pakeke	Nursery manager & Gardener	Individual and group follow up	Marae & home
	Wahine	Pakeke	Gardener	Individual and group follow up	Work & home
	Wahine	Pakeke	Gardener	Individual and group follow up	Home & home
	Wahine	Pakeke	Gardener	Individual and group follow up	Home & home
	Wahine	Kotiro	Gardener	Individual and group follow up	Home & home
	Wahine	Kuia	Gardener	Group and group follow up	Home & home
	Wahine	Kuia	Gardener	Group	Home
Nga Whare Waatea	Wahine	Pakeke	Marae manager & Gardener	Group and group follow up	Marae & marae
	Wahine	Pakeke	Social services & Gardener	Group	Marae
	Wahine	Pakeke	Social services & Gardener	Group	Marae
	Tane	Pakeke	Operations Manager	Individual and group follow up	Marae & marae
Papatūānuku	Tane	Pakeke	Garden manager	Individual and group follow up	Marae garden & marae
	Wahine	Pakeke	Gardener	Group	Marae
	Wahine	Pakeke	Gardener	Group	Marae
	Tane	Pakeke	Gardener	Group	Marae
Ōrākei	Wahine	Kuia	Garden manager	Individual	Marae nursery
	Tane	Koroua	Gardener	Group 1	Marae garden
	Tane	Koroua	Gardener	Group 1	Marae garden
	Tane	Pakeke	Gardener	Group 1	Marae garden
	Tane	Pakeke	Gardener	Group 1	Marae garden
	Tane	Koroua	Gardener	Group 2	Home
	Tane	Pakeke	Gardener	Group 2	Home
Mataatua	Wahine	Kuia	Garden manager	Individual & follow up	Marae & marae
Te Puea Memorial	Tane	Pakeke	Garden manager	Individual	Marae
Ruapotaka	Wahine	Pakeke	Social services & Garden manager	Group 1 & individual follow up	Campus & marae
	Tane	Pakeke	Gardener	Group 1	Campus
	Tane	Pakeke	Gardener	Group 2	Marae garden
	Tane	Pakeke	Gardener	Group 2	Marae garden

	Tane	Koroua	Gardener	Group 2	Marae garden

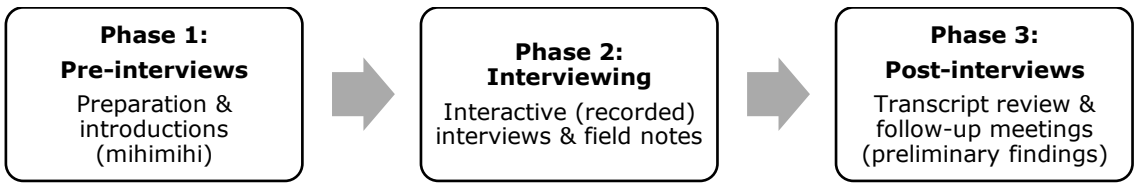
Note: the age range assigned to the respondents' are based on my estimation.

Table 3 Marae respondents' details

KEY	
SEX	**AGE RANGE**
Wahine – Female Tane - Male	Kotiro – girl (under 16) Taiohi – young adult Pakeke – adult Kuia – elder female Koroua – elder male

6.4.3 Data collection

The research design for this study utilised qualitative methods for data collection. As discussed earlier in this chapter, this design was deemed the most appropriate to uncover, compare and interpret Māori perspectives of their gardens and the marae. Qualitative interviews are one of the principal methods of obtaining data in qualitative research (Denzin & Lincoln, 2011; Marshall & Rossman, 2014). My interviews with the respondents were pre-determined as face-to-face and semi-structured to provide a forum for open dialogue in which respondents could share their experiences, tell their stories, and reveal their personal narratives. I deliberately selected 'kanohi-ki-te-kanohi' (face-to-face) interviews due to my previous research experience employing this approach. Further, my personal preference is to 'front up' to respondents, so that they can place a face to the research and connect to me through our mihimihi, discussions and consequent interviews. Presenting yourself and representing your research to respondents and interested parties is also a core principle of kaupapa Māori research (Ngā Pae o te Māramatanga, 2012). In accordance with research relationships that encompass strong ties of trust and obligation (refer Section 6.3.1), I find putting myself forward as a physical representation of my research vital. Yet, I did encounter some issues in conducting the interviews which I will discuss later in this section. There were three main phases in the data collection which I will now briefly describe and review:



Pre-interview

This first phase was largely concerned with meeting ethical requirements, and gaining entry and trust with the respondents before commencing the actual interviews. As specified in the research design, the main topic areas to be explored in the interviews were: motivations for joining in or creating the marae garden; perceived benefits and challenges of participation for themselves, family and marae members. Ten initial guide questions were developed for the interviews. However, after the first

interview and subsequent debrief with my HRC project team, we concurred the questions were problematic and leading. For example, the first set of questions included:

> Tell me about your participation in the marae food garden? What do you think are the benefits of participation for you and your whānau? Could you give me an example of the benefits? What do you think are the challenges of participation for you and your whānau? Could you give me an example of the challenges?

I found that by specifically asking about the benefits and challenges associated with gardening, I was potentially leading respondents to only think of good versus bad (hard) aspects of marae gardens. Although, this information was useful to my research, I did not want the respondents to be restricted to conversations dictated by my opening questions. In addition, because I had not yet confirmed my theoretical framework I needed to ensure I received open dialogue responses, primarily on what each respondent viewed as an important aspect of marae gardens. Essentially, I was still a little unsure of exactly how to explore the importance of basing gardens on urban marae. Thus, the initial research question was amended to:

> Talk to me about your marae garden and how it started? How long have you been involved?

This question enabled the respondents to reflect more broadly on how the garden developed for them, and why and how they became involved. As the interviews progressed, the respondents would then be asked to elaborate on points they raised in their initial reflection on the commencement of the garden, including motivations, achievements and aspirations. In retrospect, the effect of an undecided theoretical framework at the time of interviewing, combined with the need to undertake interviews in the first year of my study alongside the HRC project, meant I obtained wide-ranging data from a broad research question. Principally, I did not overly dictate the direction of the respondents' research answers. On the other hand, it would have been considerably easier for the purposes of the data analysis to have guided the interviews to directly centre on questions of cultural efficacy and capacity building from marae gardens.

Prior to the interviews taking place, all the respondents received and read their consent forms and their signatures were obtained (refer Appendix C). Three respondents elected to remain anonymous in this study. Each participant was provided with an information sheet outlining what would happen with the information they disclosed, and their control over that information (refer to Appendix B). Several respondents had attended my marae committee research presentations and were already familiar with my research intentions and outcomes. During the recruitment phase my intention was to meet each respondent prior to our interview in an effort to establish a research relationship. However, this was not possible at all the marae for two reasons. Firstly, two marae only identified the respondents on the day allocated for interviewing. Second, another marae increased the number of respondents to be interviewed on the day, and due to time constraints another team member conducted three of the interviews and I could not be present. I made several attempts to informally meet the seven

respondents I did not interview, later meeting and talking with five of this number, but two remained un-contactable. To ensure all interviews were conducted similarly, the HRC team member and I maintained field notes and undertook the first five interviews together. During the data analysis (see Section 6.5) I did detect a slight difference in the interviews conducted without me; however the variance in the data collected was not significant.

Interviewing

Each interview began with introductions and a brief overview of the research. All interviews were informal, semi-structured and conducted through guided conversations about the respondents' marae garden. In total, 19 interviews were conducted between June 2012 and June 2013 and consisted of a mix of individual and group meetings (ten individual and nine groups of two or more). Although I was prepared to conduct interviews within the more formal setting of the wharenui, none of the respondents chose to have their interviews there. As I mentioned earlier, I was accompanied on all of my interviews by a project team member who was a Māori male with extensive knowledge of gardening[21] and Māori language and protocols. This team member was purposely selected to accompany me for several reasons. First, there remain cultural protocols on marae connected to male and female roles. While I am confident to enter marae and conduct interviews as a female researcher, it was useful to have male team member to provide support. This was particularly useful when interviewing the homeless male gardeners, who appeared more at ease with my male team member present. Second, the combination of a novice (myself) and experienced gardener asking research questions provided different talking points, with some respondents more at ease in describing aspects of gardening aspects to a learner and others seeking the advice or agreement of an expert. Indeed, my team mate was asked to return to several marae at a later date to help with different tasks associated with their garden. This was also useful in establishing a rapport with many of the respondents beyond data collection.

The majority of interviews (13) were conducted on the premises of the respondents' marae, and four were conducted in and around the marae garden. During several interviews I was not only involved with interviewing the respondents, but also in being taken on a tour of the gardens and helping in and around the gardens. This led to engaging in mix of 'interactive and performative' or 'hands-on' approaches to interviewing, which I found useful to the interview process. First, we did not impede the gardeners in undertaking their everyday gardening activities and second, many gardeners appeared to be more relaxed and open to freely conversing when gardening. At the same time, I also helped with other garden chores. For example, at Ōrākei Marae with the group of homeless men gardeners, I helped peel potatoes, carrots and kūmara for their lunchtime pot of kai (food). By immersing myself in tasks and physically reviewing their garden plots, I was able to interview as the gardeners worked and found this interviewing approach to be relaxing, informal and therapeutic. Each interview lasted 1–2 hours. At the completion of the interview all the respondents were provided with a koha (gift) that included a food voucher and plant. The giving of koha is customary and a Māori protocol. Congruent

[21] I am a beginner gardener

with Māori epistemology of relational accountability, a small gift shows acknowledgement of the relationship and respect for the insights being offered. Due to my pre-interview relationship with one marae (Ōrākei Marae), I was offered access to a kawakawa plants that I could utilise as a koha to other marae and respondents I interviewed. This had a chain reaction affect that saw me collect a supply of koha plants from several marae and then share them among all the other marae. One respondent mentioned that they enjoyed this aspect of my research project, not only the sharing of plants but also the connections created between their marae. Another respondent was eager for their marae to host a plant share and exchange hui, at which point I offered to share our preliminary findings in an open meeting as a platform for this to take place. After the interviews, the respondents were each thanked for sharing their information and time and invited to attend a follow-up research meeting. Field notes were maintained to record observations related to interviews in terms of setting, and reflections on interview procedures, problems and possible areas for improvement. I asked my HRC team member to keep field notes as well, mainly on their perspective of our interviews and debriefing sessions. I found debriefing to be very beneficial in terms of ensuring out research processes were being adhered to, and that we were actively working to our research aims.

Post-interview (follow-up and data review)

All the interviews were digitally recorded and then uploaded to a university approved transcribing service that specialises in Te Reo Māori. Our elected transcriber signed a confidentiality agreement prior to the commencement of transcriptions. Copies of transcripts were sent to the respondents for their approval. Once feedback was received, they were prepared for thematic analysis. In general only minimal changes were made by the respondents. One gardener requested several amendments, in which she elaborated and clarified her discussion points. She also added photos of the development of their garden to go with her transcript. Where possible the transcripts were given directly to the gardener, but some received their transcripts via email. My preference was to give back the transcripts face-to-face to keep the research relationship strong, however not all of the respondents were available to meet. The gardeners were advised that they were welcome to make changes or provide feedback within four weeks of receipt. They were further advised that if we received no response within this time period, we would consider their transcript as accepted and approved. After this time period had elapsed, I then loaded each interview file onto a computer software programme called NVivo in preparation for data analysis (see further below).

Following the conclusion of all the interviews a meeting of the research team was convened to discuss preliminary findings and begin initial planning of the data analysis and dissemination. Follow-up interviews were offered to all marae, or new representations made since many of the gardeners had moved on since their initial interviews. Over a year had elapsed from the time of the first interview to the follow-up, which meant several respondents were no longer attending the gardens or participating in the marae. This was an accepted consequence of the length of time between interviews, and the varied nature of marae and marae participation. I held four follow-up interviews with the respondents, and two marae groups agreed to a combined meeting. At this stage I presented preliminary findings, answered any questions they had and took note of any feedback. After presenting my early findings,

several respondents approach me to further discuss the findings and some also thanked me for involving them. One group of respondents acknowledged that by bringing them together to review the findings, I had created a forum for them to reflect on their own work on the gardens which they might not have done otherwise. I was flattered by their acknowledgement and felt I was actively fulfilling my obligations to both my research and each marae. Bringing gardeners together to review my findings also had rewarding outcomes for the marae itself. Wyn (Group Follow-up, Nga Whare Waatea Marae, 26 September 2013) explained their hopes for the research results:

> … one of the outcomes would be great as to see the result of your research and the sit down with Te Puni Kōkiri and a funder and say, look a simple initiative like this we see to have hugely compounding multiplier affects across a number of outcomes, and just the cost of it, you could have a real impact on it, and what was going through my mind was quite funny, some council land that backs on to the Marae, and of course the thought is we should throw some houses on it and develop the whare, and get the council behind that, it just occurred to me, what would be more beneficial to the community would be put it in to gardens aye and bring the community out of their homes back in to the gardens as a community garden.

Several months later our research team hosted an open day hui for all the marae and I was able to invite Te Puni Kōkiri, and present my findings again to all the marae and government representatives. At this meeting, respondents were provided with the opportunity to directly engage with representatives from Te Puni Kōkiri.

6.5 Analysis

The aim of the analysis is to serve as a magnifying lens to clarify and honour the narratives. As Absolon (2008) argues, this process of sorting information that is gathered and harvested within indigenous research is 'making meaning', and it is what indigenous people do with knowledge. I worked closely with my respondents' data in an effort to make meaning from their insights and to respectfully present it as wholly as possible. I systematically reviewed all the collected data, including transcribed conversations and field notes, over a six month period before attempting to settle on set themes and findings. I then took a further six months to select and write the findings, several times go of course and having to refocus on my research intent. This stage of my research has been by far one of the most consuming in terms of time, patience and application. This has been due to several factors, including time restraints and my lack of clear direction during the data collection as I had not yet chosen my theoretical framework. I also approached my data analysis with the additional pressure of wanting to appropriately represent the respondents' opinions in the hope of highlighting research findings with a clear and significant impact for the betterment of respondents and marae. Essentially, I wanted to fulfil my responsibilities to the marae with whom I had formed relationships of trust and obligation (refer Section 6.3.1). Although, I will not relay every aspect of this phase because it was

lengthy and arduous, it did serve to make my discovery of ‘making meaning’ one of most rewarding aspects of this study.

Upon receipt of the transcripts from the transcriber, I read through each interview several times to get an overall feeling of recognition in order to identify themes. In addition, I reviewed the field notes of observations of the interviews, respondents and their settings. As I was not present in three interviews, I spent longer reading these transcripts to identify themes and to detect any noticeable differences in the data collected. Fortunately, I found corresponding themes due to the consistency of the questions asked throughout all of the interviews. Utilising the NVivo software programme for coding of the respondents text, I created nodes and sub-nodes of specific themes. I also used multiple large sheets of paper with categories and subcategories and drew visual connections between data groupings. I created a dense and detailed Excel sheet that grew as the categories expanded, and which permitted me to identify patterns through the gardeners’ responses. The Excel sheet was dense with data, but also revealed interesting gaps in the respondents’ discussions. I discuss these gaps further in the findings chapters, although I note it was surprising to see that the respondents reflections on the role of culture and the marae was not as strong as I had anticipated or presumed.

The selection of themes and coding the data were the most time consuming aspect of the analysis, and I undertook three totally different approaches before making my final selection of main themes. For example, in one of my data approaches I attempted to group data only into Māori concepts and themes (i.e. family, sharing, traditions, and marae). However, this became problematic as very few respondents spoke directly of Māori concepts and I found myself pigeonholing their data. After several attempts at analysis, my supervisor and project team members advised that I return to my conceptual framework and literature to guide my data analysis. I started my analysis again by identifying common experiences in respondents' talk. Within my broad theme of cultural efficacy, I also relied on my review of discourses regarding indigenous health promotion, urban-indigenous therapeutic landscapes and community gardens. I grouped findings around my cultural efficacy framework and arranged them under three main broad categories: people, place and activity of wellbeing (gardening). Cultural efficacy theory highlights that increased capacity is influenced by interactions between people and their environment. Within these three categories, I slowly began to see the emergence of themes related to: socialisation, sharing, autonomy, productivity, activism, participation, economic hardships, inadequate participation and funding, and many aspects connected to intergenerational factors. My categories emerged from summarising meanings, and also directly from respondents’ perspectives through concepts taken straight from the interviews. The analysis, categories, voices and the frequency of discussions allowed me to interpret my findings while my conceptual framework kept me critical in my meaning making. Once I identified and classified the main categories, I looked for direct quotes from the marae gardeners to support the category, show relationships, and produce explanations and interpretations. I also searched for the frequency of occurrences under the categories and through respondents’ voices as another way of supporting my exploration. Interpretation of data and understanding the phenomenon under study rely heavily on the researcher’s own knowledge, understanding and worldview. I present a thematic version of my research in the next three chapters. Narrative quotes are used to illustrate the essence of the themes identified.

6.6 Conclusion

The aim of this study is to provide a grounded understanding of the potential for elevating the wellbeing of indigenous peoples as a direct result of engagement in cultural-collective health activities that build cultural capacity within urban contexts. Utilising indigenous methodology frameworks was necessary to develop an understanding of the preconditions for indigenous wellbeing, particularly connected to culturally-loaded places such as marae. Highlighting and [re]claiming the functionality of marae promotes and encourages the recognition of Māori empowerment and autonomy in the delivery of health activities. Using a framework and methodology that privilege Māori perspectives and knowledge increased the applicability, efficiency and effectiveness of the research process of data collection and analysis. The design of this study was guided by the intention that it contribute to a better understanding of urban marae and developing cultural capacity. Generating knowledge about marae initiatives that may enhance wellbeing in the broadest sense identifies and supports effective marae-based activities for families. This holds potential to address a broader range of relevant factors within the social, cultural, historical and wider contexts. The concepts of kaupapa Māori research provided valuable research methods that allowed both me and the respondents to inhabit a culturally safe and valued space to share knowledge and learning. Cultural efficacy theory formed a base from which I could investigate experiences of cultural capacity and efficacy building within culturally loaded spaces. The results of my methodological approach in the upcoming findings chapters provide a significant argument to challenge dominant health systems understandings of how to support and improve indigenous wellbeing.

Figure 9: Ōrākei Marae 3

Auckland City Mission gardeners' plan for their garden in the shape of a waka (canoe)

Chapter 7 Marae gardening: an everyday activity of multifaceted experiences

Figure 10: Makaurau Marae 1

Photo 1 – Individual whānau garden boxes
Photo 2 – Native plants nursery adjacent to whānau garden boxes

7.1 Introduction

This chapter is the first of three discussion chapters in which I extend my central argument that cultural-collective health activities situated within culturally-loaded places are effective indigenous health strategies because they develop cultural capacity. In the preceding chapters, I have noted that urban-indigenous community gardens entail cultural-collective features and empowering experiences that contribute to cultural capacity, and consequently indigenous health autonomy and family wellbeing. Thus, community gardens located within urban marae provide an important practical illustration of the influences and outcomes of Māori engagement. Commencing in this chapter, I focus on the wellbeing features of Māori participation in urban marae community gardens. Herein I argue that individualised health programmes continue to lack universal relevance for indigenous peoples. This is because collective experiences and benefits continue to remain a priority for Māori. In my next chapter I demonstrate that social factors are an essential precondition for improved urban Māori health and wellbeing. These social features include being among Māori, and connecting and sharing. Last, in Chapter 9, I show that urban marae have an integral role in facilitating effective and relevant health programmes for Māori. Therein, I culminate my argument that urban marae are comprehensive health delivery sites because they are sociocultural places that develop cultural capacity while improving Māori health.

Throughout this chapter, I demonstrate that community gardening within urban marae involves both direct and indirect experiences that provide multifaceted wellbeing benefits and develop Māori cultural capacity. In Section 7.2, I show that motivation for marae garden engagement is varied, but primarily influenced by collective factors. Notably, all of the respondents had expectations of collective experiences and benefits centred on family wellbeing. Thus, individualised health approaches centred on individual gains are incompatible for Māori who prioritise family wellbeing before personal factors. In Sections 7.2.1 and 7.2.2, I discuss both the family health benefits and therapeutic experiences derived from active participation in urban marae gardens. Next, in section 7.3, I show that the urban

marae gardens involve empowering, although often understated collective experiences that develop and reinforce cultural capacity. Within the marae gardens the respondents' cultural capacity and autonomy is empowered as they manage their garden plots. Many of the respondents viewed their community garden contributions not only as a means to address family health requirements, but also local and wider issues such as food insecurity. In Section 7.3.1, I demonstrate that by addressing these health issues prevalent in their communities, the respondents were also engaging in understated experiences of grassroots local activism. I argue that these experiences of local activism develop cultural capacity as the respondents mobilise to make both direct and indirect stances against local injustices. Last, in Section 7.4, I show that food gardens on marae entail challenging experiences of contestation due to ongoing sustainability issues. Notably, these challenges can result in either an increase or decrease of cultural capacity and confidence. Further, marae gardens represent a paradox for urban marae and the respondents in terms of supporting and rejecting neoliberalism. Ultimately, all of these ongoing contentious issues threaten the future of urban marae and the development of cultural-collective health programmes.

Before furthering my discussions, I will first clarify that a large majority of conversations with the respondents detailed their food growing experiences, including varieties of produce and results. While these conversations were lengthy, and for some respondents their main topic points, it is the sociocultural centred discussions I focus on in the upcoming sections and chapters. As a consequence, some respondents who spoke more about the social aspects of gardening feature more prominently than the small number who did not. Further, while it may appear in the following discussions that the methods, types and experiments involved in growing fresh food were barely discussed, this was not the case. At another time, I will revisit and review the substantial amount information amassed on this topic. Nonetheless, at this point, I acknowledge that the lack of discussions on the garden produce is deliberate and a result of my bias toward understanding the social and cultural implications of urban marae gardens and Māori wellbeing.

7.2 Ordinary and healthy experiences for family wellbeing

As I discussed in Chapter 4, indigenous community gardens encompass an ordinary health activity that can entail both cultural and collective experiences alongside nutritional benefits for family wellbeing. In urban centres, community gardens provide a place and opportunity for family members to participate in collective experiences of growing food and developing gardening skills (Wen Li et al., 2010). Yet, determining influences on individual and family participation in community gardens can be complex due to the diverse living circumstances of indigenous and non-indigenous peoples. In turn community gardeners are influenced by a combination of health, economic, social and cultural reasons (Alaimo et al., 2016). While some indigenous studies have indicated that family and cultural factors can be leading influences (Stronik et al., 2010), the respondents confirmed that identifying exact motivations is difficult. For example, one gardener (Interview, Homeless Men's Group, Ōrākei marae, 24 May 2012) explained he had free time and "had nothing else to do". Other gardeners made it clear they simply enjoyed gardening. Tracey (Interview, Tracey, Makaurau Marae, 15 May 2012)

joked, “I’m not quite sure why I’m here [laughs] … who sent me here… but I know every time I’m here I love it, so yeah”. Nevertheless, there was consensus among the respondents that family factors were a main influence for their community garden engagement. Importantly, there was universal agreement that family or collective orientated factors were the most important expected outcomes. One respondent (Interview, Anon. 1, Makaurau Marae, 27 June 2012) aptly conveyed the perspectives of many of the other gardeners:

> I like that it links me back to my childhood and to my grandfather especially, I like that it links me to my dad and my daughter and seeing how it builds that relationship … I think I see what gardens can do with that whole thing with being with whānau and being around whānau and talking with whānau about relationships, if you don’t have that you don’t have anything really, pretty sour garden if you’re just working on your own for your own benefit you know? But when you’re sharing it, sharing information then that’s a good thing, share kai at the end, and share knowledge and share space.

This respondent’s descriptions highlight the importance of the collective features of gardens that centre on family relationships, connecting and sharing. Another respondent (Interview, Anon. 2, Makaurau Marae, 18 July 2012) from the same marae was clear on the collective intentions of her fellow gardeners: “We’re all like-minded in terms of what we think that the [marae garden and] nursery can do, it’s not what everybody can do for us, it’s what we can do for everybody … to make their lives better”. The collective benefits of improved family relationships and health were consistently emphasised among the respondents more than any other gardening influences or outcomes (see further Chapter 8). Notably, almost none of the respondents spoke in terms of their personal motivations or outcomes linked to marae gardening participation. This lack of discussion regarding personal factors associated with marae garden participation strengthens my argument (see Chapter 2 & 3) that indigenous health programmes may be less applicable when individually focused or outcome driven (Baum & Fisher, 2014). Many indigenous peoples continue to prioritise collective wellbeing outcomes for the immediate and wider family over personal benefits (Hardin, 2015). The respondents’ discussions confirmed that collective experiences and benefits were an essential feature of marae gardening which had either influenced or were sustaining their current participation.

As the respondents spoke of their marae garden engagement they revealed many common observations and experiences, including that marae gardening was a relaxing, simple and familiar activity. The simple nature of the work was described by Ngahuia (Interview, Ngahuia, Ōrākei Marae, 16 May 2012): “You work the soil, and work hard and [when] you work in the garden something good is gonna come from it ... you’re gonna provide something, you’re gonna feel good about it, and you’ve put in a good days work”. Similar observations by other respondents confirmed the ‘everyday and ordinary’ features of gardening, yet wide ranging physical and mental health benefits (P. King et al., 2015; Kingsley & Townsend, 2006). All the respondents considered gardening a healthy activity for all family members, young and old, and one that does not rely on specialised skills and knowledge. However, one respondent also contended that gardening is a natural skill for Māori, nurtured through

childhood experiences. Brian (Interview, Group 2, Ruapotaka Marae, 3 August 2012) spoke of his family's aptitude for gardening:

> … from the time we were born, we were natural gardeners because …everything…all the practice on the farm back home was mainly to do with the soil, to do with gardening … so we would follow around our nana and our koro (grandfathers) and what they were doing and … so even today we still have the knowledge it's just a matter of bringing that out and utilising that what we born with.

In terms of gardening experience or abilities, almost all of the respondents had prior experience working in food gardens, either home or community-based. Only three of the younger gardeners, who were aged under 20, had limited experience. Incorporating and capitalising on existing community skills within health programmes has been shown to not only influence indigenous community participation, but also ensure more effective and appropriate wellbeing outcomes (Barnett & Kendall, 2011). Many of the more experienced gardeners indicated that marae gardens provide a place for shared learning experiences, and they were happy to share their expertise with younger and less experienced gardeners.

A large majority of the respondents expressed appreciation of regular engagement in a collective activity that for the most part was voluntary and self-directed (Alaimo et al., 2016). In contrast with conventional health programmes that are education-focused with predetermined measures or outcomes (Pholi et al., 2009), the less structured approach of marae gardens appeared to be an important feature for several respondents. For example, Lionel (Interview, Lionel, Papatūānuku Kōkiri marae, 24 May 2012) argued that he enjoyed the relaxed yet autonomous characteristics of marae gardens: "Just having the freedom to do what we do without too many restrictions, not too many chiefs, you know? It's just the freedom and the peace … and it's good too when you finish a project … like when you start something and then you see the end of it". Lionel's comments highlight an ongoing debate within the literature of the necessity of incorporating programme features that are more collective and culturally centred into indigenous health strategies to increase their relevance (Cain et al., 2013; Dutta, 2016). As emphasised in Chapter 3, it is apparent that the more relaxed and collective health approach underpinning marae gardening was crucial for the respondents. Yet, as I show further below, improving family health was paramount for the respondents, alongside everyday therapeutic experiences and benefits.

7.2.1 Healthy Māori families

Family health factors associated with marae gardening was a consistent discussion topic for all of the respondents. Wide ranging factors in Māori health and wellbeing were reviewed, including: current and past health issues, health risks, food quality, exercise, dietary habits and living conditions (Lombard et al., 2014; Mangadu et al., 2016). All of the respondents who spoke about family health were aware of the persistent challenges, both social and structural, faced by their family members (Dutta, 2016;

Wirihana & Smith, 2014). Three respondents who worked in health spoke directly of the current health inequities and access barriers to health services for Māori in New Zealand (Came et al., 2016). As discussed in Chapter 3, the poor health of indigenous peoples can be attributed to the experience of substantial disparities that have impacted their health and wellbeing. Many among the respondent group discussed their first-hand knowledge of local conditions and lifestyle factors that have affected the wellbeing of their own families and the wider Māori community. This included understandings of the health gap between Māori and non-Māori people in relation to chronic disease, obesity, infant morbidity, smoking and cardiovascular disease (Theodore et al., 2015). A small number of respondents indicated that Māori families need to make some improvements in food choices toward more healthy diets. Yet, as I discuss further in Section 7.3.1, these respondents noted that socioeconomic and environmental factors influence dietary habits and access to fresh foods (Ghose & Pettygrove, 2014a). Many of the community gardens were located in lower socioeconomic communities, hence several respondents acknowledged that current living circumstances were impacting their family's health (J. Reid et al., 2013). Nonetheless, there was agreement among the respondents of the small yet significant contributions marae community gardens could make in terms of the provision of fresh food.

One respondent indicated that the overall poor health of many close community members inspired her marae to initiate a community garden. She (Interview, Anon. 1, Makaurau Marae, 27 June 2012) explained: "We've tried to tackle health issues such as obesity … which is an issue, diabetes which is an issue, now we've got people dying of cancer … and we thought maybe if we grow our own food ...".This gardener felt the marae gardens could have a direct effect on all family members, elaborating further:

> We believe if they're eating healthier, that if everybody's eating healthier... say from my grandson - or maybe a bit older, from my grandnephew and nieces, their generation wouldn't be affected as much by diabetes, that's the ultimate goal and that's what we want to achieve.

This quotation reflects a common motivation among the respondents for setting up or being involved in marae gardens. Seven of the respondents had initiated their marae community gardens with the intention that all marae stakeholders be able to access fresh food from their gardens as a means to improve family diets. Providing better quality food alternatives was a main discussion topic among the gardeners (Mundel & Chapman, 2010; Stang, 2009). One respondent (Interview, Anon. 2, Makaurau, 18 July 2012) argued further that marae community gardens provide Māori families with better lifestyle choices:

> …it changes their whole lifestyle choices, and that's just by having a garden or tending a garden … I recall what it provided for my family when I was young is that everyone came and helped out, that's what we did on the weekend and my grandfather and I … during the week … yeah it became the [community] centre.

A small number of the respondents speculated on the contribution of marae gardens in assisting unemployed or low income families. Tracey (Interview, Tracey, Makaurau Marae, 15 May 2012) reflected on the unemployment situation in her community: “A lot of our whānau are unemployed and can hardly you know afford bread and milk and some of them have big families. Some of them live with their mums and dads and have kids of their own”. Tracey argued that marae garden involvement could make a difference to the food bills and promote healthy food intake for local family members. Another gardener (Interview, Anon. 2, Makaurau, 18 July 2012) from the same marae commented that gardens have a dual role in improving family diets and providing younger community members with employable skills: “We have a high unemployed rate … but for those that are in school we’re hoping that we’re able to get them in to horticulture”. Other respondents spoke of creating an income and a sustainable way of living from selling garden produce. In this regard, three members from one marae indicated that they sold produce from their gardens to support gardening projects aimed at helping families. Further, this marae encouraged families to utilise the marae gardens to grow food to sell and supplement their incomes. Later, in Chapter 9, I further review the effect of socioeconomic living environments on Māori health.

Helping families experiencing hardship was the primary motivation for one student respondent. This gardener (Interview, Student Group, Manurewa marae, 24 October 2012) spoke of the mutual wellbeing benefits for the gardener and recipients of providing free food from marae gardens:

> … because it’s charitable it’s even better, we don’t benefit from it financially … now the community know where they can go and get a feed, and in these economic times it’s really hard feeding the kids, feeding the family, managing the income.

This respondent illustrated the economic pressures faced by many local families and the basic need to provide food. Another gardener (Interview, Anon. 2, Makaurau Marae, 18 July 2012) summed up the perspectives of many of the gardeners when she argued that the benefits of marae gardens are directly connected to improving family wellbeing for the future. She made her point clear:

> The long term goal is that we have a healthy race of people … my dad is XXXXs brother, and he died a couple of years back, but all his first cousins and that’s probably about fifteen men are all dead, and they’ve all died through diabetes or related diseases, so my first cousins and my second cousins now, I’d say ninety percent of them are diabetic …

Unfortunately, this gardener’s experience of poor health in her family was not uncommon as a large majority of the gardeners also spoke of the prevalence of chronic illness in their families (see Chapter 3). These concerns correspond with international studies that have shown poor diet remains a significant health issue for indigenous communities (Gittelsohn & Rowan, 2011; E. L. Mead, Gittelsohn, Roache, Corriveau, & Sharma, 2013). According to two respondents, providing fresh produce from the marae gardens will ultimately contribute to family longevity. As one gardener (Interview, Anon. 2, Makaurau, 18 July 2012) joked, “… the up-side of that is that if they eat

vegetables they're healthier, the other side of that is … not dying!". Notwithstanding, there was general agreement among the respondents that marae gardens had an important role in providing healthy fresh food on the tables of the marae and in their homes. Improved food quality and availability is consistently highlighted in the health literature as an important outcome of indigenous community gardens (Lombard et al., 2014; Taima Moeke-Pickering et al., 2015).

Interestingly, although numerous studies have identified physical wellbeing as a leading outcome of garden participation (Alaimo et al., 2016; Draper & Freedman, 2010; Hartwig & Mason, 2016), it was seldom mentioned by the gardeners. Several gardeners spoke of physical activity as a benefit of gardening, but they did not describe the extent or regularly of their personal exercise. Yet this lack of discussion regarding their personal exercise undertaken while gardening is not surprising considering my earlier argument that personal benefits were seldom described by the respondents. I surmise that they deemed their physical activity as low-key or not as significant as the many other family benefits they identified. While very few of the respondents discussed their gardens as a health activity or programme, concern with healthy Māori families was clearly foremost in their gardening engagement.

7.2.2 Therapeutic experiences in urban marae gardens

Community gardening involves therapeutic experiences that contribute to improved mental and emotional health (Hale et al., 2011; Pitt, 2014; J. J. P. Robson & Troutman-Jordan, 2015). As I suggested in Chapter 4, urban marae gardens can be aligned to urban-indigenous therapeutic landscapes due to their function as an everyday place for Māori to be among Māori and surrounded by their culture while participating in health activities (Wendt & Gone, 2012a). Throughout my discussion chapters, I expand on the urban-indigenous therapeutic landscape features of marae gardens. However, in this section I focus on the everyday holistic healing and land-interaction features of marae gardens described by the respondents. These discussions highlight the importance of land-based initiatives and therapeutic experiences for indigenous peoples' wellbeing (see Redvers, 2016) (see further Chapter 9). Two respondents spoke directly about the therapeutic benefits of community gardening within marae. Mereana (Interview, Group, Nga Whare Waatea marae, 21 June 2013) provided a uniquely Māori perspective regarding the holistic role of both garden and marae for Māori:

> Well I think the marae is the māra in more ways than one, just about feeding the physical … it's about the soul, the heart, all those things … the kai side of the māra is … it's about the physical being, then you have other areas of māra that are to do with the wairua (spirit), then you have other māra that are to do with the hinengaro (mind).

This quotation reflects a unified view of the physical and metaphysical world held by several of the respondents, which aligns to the Māori health and wellness model 'Te Whare Tapa Whā', developed by Māori health expert Mason Durie (1985). This model takes a holistic perspective on wellbeing, describing the balance required between spiritual, physical, mental and family wellbeing. The holistic benefits of the gardens were further elucidated by Lionel (Interview, Lionel, Papatūānuku Kōkiri

Marae, 24 May 2012), when he equated the current health of Māori with his experience of the multi-faceted aspects of gardens:

> Heaps of benefits … culturally, whakapapa … everything has got a whakapapa, everything has got a purpose … you know? The diabetes thing, you know all the unhealthy stuff has heaps of different aspects, depends on how you look at it, its [marae garden] got all these benefits … getting people together, stress relief … you know, it's a big stress relief, bit of time out, good for mental health … you know? By yourself in the sun, nothing like it, working and getting your hands dirty, it's good for you … something to look forward to.

Lionel's comprehensive review of the wide ranging benefits of active engagement in the gardens highlights the holistic experiences and outcomes for Māori health. Hence, the simple and ordinary health activity of marae gardening was considered by several respondents as a means for Māori to connect physically, socially and culturally to their living environment (P. King et al., 2015). This corresponds with the findings of many indigenous health studies that land connectedness for urban indigenous peoples can both empower and promote health (Kingsley, Townsend, Phillips, et al., 2009; J K. Tobias & Richmond, 2014).

This physical connection to land and the benefits of outdoor activity was highlighted by many respondents. The respondents emphasised a combination of healing features from gardens that enabled relaxation, therapy and spiritual connections through contact with their natural environment (Kingsley, Townsend, Phillips, et al., 2009; Sanchez & Liamputtong, 2017). For example, a student gardener (Interview, Student Group, Manurewa Marae, 24 October 2012) made the following observation:

> … idle hands are the devils tool, so you're doing something practical, beneficial, your lungs are getting filled with fresh, you're out in the sun so you're getting … accumulating enough vitamin K and C … things like that, the joy is that you eat it … and you can't tell me that there's a person on this planet earth that don't like eating.

Other respondents regarded community gardening as a form of holistic healing or treatment (see further Bignante, 2015). Kylie (Interview, Group, Nga Whare Waatea Marae, 21 June 2013) described her gardening activity as a complete treatment because it was a place and activity for healing and fixing things. She took pride in her therapeutic interactions with the garden: "… [the garden is] an area for dropping your crap in, and turning the soil over for better words, and just ripping it out and sorting it out … and then bang you've got a solution". As described by Kylie, frustrations could be brought to the gardens and worked on. Similarly, two other respondents emphasised the healing qualities of gardening: "It's also been a healing and a ... it's been therapy for me and me and my sister, it's been a therapy thing for us" (Interview, Group, Papatūānuku Kōkiri Marae, 27 July 2012). Brian (Interview, Group 2, Ruapotaka Marae, 3 August 2012) also spoke of gardening as a form of rehabilitation: "Its healing for what you are doing…we have a lot of spiritual values attached to our work, our mahi and

our personal opinion if you want to find out how to get close to god it's here…and here it is here the trees, its nature…there is something in this soil". This spiritual aspect of gardening was important for Brian who identified himself as a religious person and reflected that for him his efforts in the gardens brought him closer to God, the soil and sustenance and energy for his body. Thus, the gardens can represent more than a physical location of healing: they reinforce connections or relationships between the physical, spiritual, and symbolic realms of indigenous identities (K. Wilson, 2003).

Hence, for many of the gardeners working on the land was considered a rewarding means of interacting with Papatūānuku and an essential therapeutic experience (M. Kawharu, 2010). Urban marae have provided tangible everyday opportunities for Māori to engage in nature contact (Hale et al., 2011). As two gardeners (Interview, Grant & Nic, Ōrākei Marae, 10 October 2012) posited, this land connection and the associated interactions are "powerful stuff" to Māori wellbeing. They also spoke of the interaction between people and the land, and the wellbeing derived from these interactions: "I suppose it's that interaction with plant life and yourself in the garden that gives you that and the plants feel that relationship that you have and they do well because of the water that you're giving them". Another gardener, Brian (Interview, Group 2, Ruapotaka Marae, 3 August 2012), viewed his work in the garden as a gift: "…well the challenge is up to yourself…if you are working with nature and Papatūānuku the garden…earth that's all natural…it's kind of like it's a gift for you, a taonga…you just need to take it up, you know accept that challenge". Several gardeners commented that urban living, especially apartments, often results in limited access to land and that marae gardens were the only means for Māori to establish or reinforce land connectedness. These varied therapeutic experiences linked to garden participation were vital for the respondents, contributing to a sense of wellbeing and connection to their local environments (Milligan et al., 2015; Sanchez & Liamputtong, 2017). Later in Chapter 9, I provide further analysis of the role of marae as a physical place that contributes to the specific wellbeing needs of urban Māori.

This section has demonstrated that marae gardening is universally viewed by the respondents as a collective activity that can make important contributions to Māori family health and wellbeing. The collective wellbeing features and benefits of community gardens are both an influence and outcome of participation. Further, the simple and ordinary nature of gardening is considered an important feature. It was also clear from the respondents' discussions that gardening is an important therapeutic activity which has healing consequences for Māori health. Moreover, Māori can connect to the land both physically and spiritually. In my next section, I review the contributory role of community gardens in developing the cultural capacity and autonomy of urban Māori.

7.3 Everyday and understated experiences of empowering cultural capacity

Figure 11: Manurewa Marae 1

Photo 1 – Overview of Manurewa marae māra kai including composting bins and worm farm
Photo 2 – Manurewa Horticulture students' gardens

In Chapter 2, I argued that the development of cultural efficacy leads to increased confidence and capacity within indigenous groups to effectively mobilise and address collectively identified issues and goals. As demonstrated in Chapter 4, community garden engagement for indigenous groups increases their cultural knowledges, skills and capabilities (Stronik et al., 2010; Wen Li et al., 2010). This is because community gardens provide a physical place for indigenous peoples to gather and engage in sociocultural practices and experiences that build cultural efficacy. However, it is important to note Houkamau's (2011) argument that cultural efficacy, and awareness of cultural group and capabilities (and the lack thereof), can in turn repel indigenous peoples' commitment and engagement. This may be a contributory factor to low participation in many of the urban marae gardens (see further Section 7.4.2). Nonetheless, health approaches that capitalise on factors associated with cultural efficacy, such as indigenous autonomy, can work to improve wellbeing outcomes for indigenous people (see further Chapter 2). Accordingly, community gardens provide an ideal platform to develop cultural efficacy because they encompass a multitude of features that contribute to indigenous wellbeing, including collective-level empowerment, cultural awareness and pride, ownership and social support (Alaimo et al., 2016; Okvat & Zautra, 2011). More importantly, as I argue further below, everyday experiences and actions within marae gardens empower Māori health autonomy.

Foremost, I note that each respondent possessed at least a minimal degree of cultural efficacy that enabled them to enter and work on the gardens within their marae. By virtue of their active involvement in the gardens, I assumed that all the gardeners were both familiar and comfortable with the marae setting. None of the respondents spoke of any uncertainty or discomfort about their personal engagement with marae or the garden. Still, one respondent indicated that he had little involvement with the marae in any capacity other than tending the community garden. It is important to note that I did not query any of the respondents on the extent of their cultural knowledge or capability regarding the marae environment (Houkamau & Sibley, 2011). I readily admit this had a regrettable consequence evident in the lack of conversations that specifically address the role of cultural efficacy within marae gardens. The oversight was due to the late selection of my theoretical framework, and limited direct or lengthy discussions regarding marae access, or comfort with being on the marae,

which may have provided some useful insights (refer Chapter 6). Yet, fortunately, indirect or unintentional nuances in our conservations can be attributed to factors associated with cultural efficacy. Notwithstanding, none of the gardeners were new to marae or unaware of the workings of marae and gardens. As one student gardener (Interview, Student Group, Manurewa Marae, 24 October 2012) noted: "…everyone understands their place in the … running of the community [garden on] the marae". Hence, I maintain all the respondents had a minimal level of cultural efficacy, and, as I discuss below, for many respondents their marae experiences were contributing to further development of their cultural confidence and capacities.

At face value, community gardens represent the commitment of a collective group of people to work together to produce food. Productive gardens are considered to be a testament to the social cohesion of a group in willingly sharing space, mutual knowledge and skills for collective benefits (Lainer et al., 2015; Pearson & Firth, 2012; Teig et al., 2009). As expressed by one student gardener, the gardens showed her community working together to produce 'good crops' (Interview, Student Group, Manurewa marae, 24 October 2012). This was the general consensus among all the respondents. Empowering experiences within the marae gardens contributing to autonomy was a recurrent theme in the discussions regarding garden engagement. As demonstrated in Chapter 3, control over life is an important determinant of indigenous wellbeing, and researchers argue that autonomy needs to be exercised where possible within indigenous communities or places (Kirmayer, Dandeneau, Marshall, Phillips, & Williamson, 2011; Orbach, 2011). Community garden studies also show that autonomy is evident when gardeners set goals for their garden space and display control of their resources and environment (Milburn & Vail, 2010; Okvat & Zautra, 2011). By word or action, all of the gardeners expressed confidence in their abilities in the gardens and exercised autonomy within their gardens.

As a majority of my interviews or follow-up visits involved a tour of each marae garden, all the gardeners were able to show and discuss the decisions made regarding their produce. It was apparent to me as an observer that all of the gardeners took pride in their ability to effectively manage their gardens and grow produce. Brian (Interview, Group 2, Ruapotaka marae, 3 August 2012) commented on the importance of having control over the garden: "The satisfaction of the mind knowing that it's something so simple, that they can do it, and the satisfaction of taking it from the start to completion". The experiences of these gardeners are supported by Okvat's (2011) work on community gardens in urban centres which showed that gardening provides crucial wellbeing experiences of empowerment from mastery experiences connected to decision-making and control of garden produce, land and tools. By situating gardens within marae there are clear opportunities for developing both the personal and collective autonomy of each of the gardeners, as the make decisions regarding varieties of produce, methods of garden maintenance and produce sharing. Principally marae gardens can be viewed as an empowering source of autonomy because the success and quality of the gardens are reliant on the skills and knowledge of all community members.

Two respondents described their satisfaction in providing free produce for their marae-based Kōhanga Reo through their collective efforts to mobilise community assistance. Kylie (Interview, Group, Nga Whare Waatea Marae, 21 June 2013) explained:

> … when we put our heads together … we spent one whole day focussing on the things we could try and get for free and utilise whānau and friends … and businesses that we could to sustain that money pool to be able to feed more to the Kōhanga.

The act of providing for others selflessly was an important outcome of the gardens for the majority of the gardeners. Another gardener spoke of notions of autonomy when reviewing their contribution to the food served on marae: "We can control [our food] … like when it's a marae do (function) at home … we've become a bit more conscious about what we serve" (Interview, Anon. 2, Makaurau Marae, 18 July 2012). The marae with gardens reaped the benefits of the gardeners' efforts as produce was primarily for the marae kitchen first and the homes of family members second. In this regard, a small number of the gardeners noted their contributions to controlling the quality and quantity of food given to their marae. Other features of autonomy were discussed in a variety of ways among the respondents. Teri (Interview, Teri, Te Puea Marae, 24 October 2012) spoke of his individual autonomy in the gardens in that he could garden at 'random' times and commit time and effort as he chose. In terms of marae garden engagement, many of the gardeners deemed it important that they could choose the amount of time and input they invested in their gardens.

In Chapter 4, I demonstrated that urban indigenous community gardens can actively increase autonomy as gardeners participate in empowering processes such as decision-making and taking control (Barron, 2016; Cidro et al., 2016). Within indigenous communities, local capacity, including cultural capacity, can be built as stakeholders exercise their autonomy in local issues such as improved food quality and quantity (Stang, 2009). As I argued earlier, the everyday actions and experiences of marae gardens serve to empower Māori health autonomy. Next, I develop this argument by reviewing the respondents' experiences of understated local activism as they address local food issues. In this regard, several marae community gardens are being utilised to contribute to alternative food movements and indigenous food sovereignty efforts (Cidro et al., 2015; Taima Moeke-Pickering et al., 2015).

7.3.1 Local activism and alternative food movements

As I demonstrated in Chapter 4, urban-indigenous community gardens can be employed as a politicised grassroots site to address concerns of local injustice (Block et al., 2012; Certomà, 2015). This involves challenging dominant power relations that contribute to social injustices within indigenous and disadvantaged communities (Ghose & Pettygrove, 2014a; McClintock, 2013). As Milbourne (2012, p. 942) argues, community gardens are "mundane forms of (in)justice" within everyday spaces". This is because community gardens are ordinary social gathering places in which community members can determine their participation in different scales of community action. Notably, the majority of the gardeners did not discuss their marae gardens as a site for social action, or engaging in local activism. Yet, their conversations often revealed actions or intentions toward subtle or understated forms of activism. Fortunately, a small number a respondents spoke directly of their intentions to address local health issues affecting the wellbeing of their families, marae and wider

community. These respondents were clear that community gardens within their own, often lower socioeconomic communities were a necessity for providing an alternative food source (Litt et al., 2011) (see Chapter 6). Interestingly, while many respondents often minimised the significance of their collective actions and stance from within their gardens, as I show below, they were in fact empowering their cultural capacity and health autonomy. The respondents' commitment to the gardens demonstrated their collective voice and action in providing an alternative food source for their families.

One of the most apparent contributions to local activism was the involvement of marae gardens within the alternative food movement (Beckie et al., 2012; Kassa, 2016). In urban centres, community gardens sit within alternative food systems because they provide a cheaper and chemical free option to conventional food supply systems, such as supermarkets, fast-food outlets and convenience stores (Block et al., 2012; McClintock, 2013; A. D. Wilson, 2013). Further, emerging studies have identified that urban-indigenous community gardens have an increasingly important role in indigenous food sovereignty through enhancing food security and growing traditional foods (Cidro et al., 2015; Taima Moeke-Pickering et al., 2015). When considering the availability of fresh produce in their communities, several gardeners spoke not only of their dissatisfaction with conventional food systems in terms of cost and availability, but also the quality. Three gardeners commented that wanting to ensure their food was organic and locally grown was a major reason for growing their own food on marae. Ngahuia (Interview, Ngahuia, Ōrākei Marae, 16 May 2012) spoke of the significance of both these influences for encouraging local marae members to garden: "Look let's make a garden; you know and feed our people, and it's organically grown you know, you don't know where those vegetables come from, what blimmin chemical's they have put on them". Other respondents were similarly concerned with the quality of produce available within their communities and were eager to grow organic food within their own marae garden, or expand their current crops. In this regard, for the respondents from Papatūānuku Kōkiri Marae ensuring that their marae lands and the gardens were not 'tainted by sprays' was vital. One gardener (Interview, Group, Papatūānuku Kōkiri marae, 27 July 2012) in the group explained their marae garden ethos: "We're trying to go organic. Everything organic, we're not allowed to use sprays of anything like, weed killer. We try and just keep it as, you know, the old natural way of having to pull the weeds out by hand". Teri (Interview, Teri, Te Puea Marae, 24 October 2012) noted there were difficulties in maintaining organic gardens in cities, citing the example of the council weed spraying near his marae which spread chemical agents across his land. Nevertheless, the four gardeners from Papatūānuku Kōkiri Marae were in the process of ensuring their marae would be the first urban marae to achieve organic certification (Hutchings et al., 2012).

Another local concern for many of the respondents was the effect of convenience or fast foods for the health and wellbeing of their families and community. A small number of gardeners also commented that Māori families were increasingly becoming implicated in consumerism and choosing not to grow their own food. Laziness had crept into Māori families according to Brian (Interview, Group 2, Ruapotaka marae, 3 August 2012): "My aunties and uncles they got a bit lazy you know laziness set in, it's easier to go over and buy a bunch of silver beet for a dollar…you know you can just put down your packet of seeds and raise your own…and grow your own veges". Another respondent (Interview, Student Group, Manurewa Marae, 24 October 2012) added that produce from the garden tastes

better: "… they'll probably be surprised themselves, when they see it growing and then you realised 'Oh you can eat it and it tastes better than buying it from the shop'". The ability to control food quality and increase access to healthy food in urban centres through community gardening was expressed by many respondents, reflecting the current struggle for Māori individual and collective autonomy over food, including traditional kai (food) (McKerchar et al., 2014; Taima Moeke-Pickering et al., 2015). A common opinion expressed by the gardeners is that buying vegetables from a supermarket is unacceptable when they are easily grown in gardens. Gardeners also noted that too many families rely heavily on supermarkets and convenience stores. This is consistent with health studies that have demonstrated the enduring effect of convenience foods on the health of indigenous peoples (Taima Moeke-Pickering et al., 2015; Skinner et al., 2016; S. L. Thompson et al., 2013). Six respondents argued that gardening can reduce Māori families' reliance on convenience stores and fast-foods. This group implied that their involvement in food gardens is an act of resistance against these unhealthy food choices. Delwyn (Interview, Delwyn, Makaurau Marae, 3 August 2012) typified the concern held by several respondents, regarding the effect of convenience foods on wellbeing and the role of marae and their gardens in combatting it. She felt strongly that Māori communities need to petition the government to create healthier communities by limiting not only fast-food outlets, but also liquor stores:

> … lobby your local council, stop licensing within so many kilometres in a certain area and stop … lobby your council and the government to change laws around; to look at dairies, and shops and takeaways, you know? There should only be one McDonalds in a bloody twenty-kilometre zone … We need to have more fruit and vege, and you can't … if there's commercial … you can't keep whacking at "Diabetes kills people". We all know that; well why? Get to the heart of it. It's what we're doing in our communities.

She continued:

> Don't sell our souls and prostitute ourselves for a bit of money so we keep the building going when you're selling … you're killing people saying it's ok to eat a fry from McDonalds. We all eat McDonalds … I'm not saying you can't have moderation, but some people can't have moderation, so you know? So communities… through marae is healthy eating … better eating, free … and everybody can do it.

Delwyn's assertive and illuminating stance on convenience foods in her community contains several important arguments regarding future Māori wellbeing. Significant to this study is the notion that marae gardens and participating families can play an important and active role in the healthier diets of urban Māori, and the collective action required can be marshalled from within marae communities (Taima Moeke-Pickering et al., 2015). These discussions also reveal an awareness of the urban specific issues that affect the diets of Māori, including the ease of access to fast-foods.

Price was another factor for several respondents who emphasised marae produce as a cheaper alternative to store brought foods. Almost all of the respondents, who spoke about high food costs, noted that growing your own food is considerably cheaper. One exception was Brian (Interview, Group 2, Ruapotaka Marae, 3 August 2012), who argued supermarkets were cheaper, although, as a counterpoint to his argument, he noted the problem with cheap supermarket produce is not knowing where it has come from, or the chemicals used. Two gardeners (Interview, Grant & Nic, Ōrākei Marae, 10 October 2012) expressed concerns over the affordability of fresh vegetables and fruit, and challenged the government over the taxes placed on fresh produce:

> … they are so overpriced and yet they are so essential for you, and with the government why don't they just take GST off veggies and fruit. Don't have to take them off alcohol and cigarettes, double it on alcohol and cigarettes, but when it comes to veggies and fruits that they're trying to sell to us to eat and then you're gonna charge $4.99 for a cauli[flower].

They contended that fresh produce was often overpriced and unaffordable, which affected family food budgets and diets. The question of whether convenience food is cheaper than food grown in alternative systems is also debated in academic studies (Andrew Hume et al., 2013; Poulsen et al., 2014; Rudolph & McLachlan, 2013). Nonetheless, the majority of the respondents acknowledged that there were many issues with convenience foods, and four commented that it was a community and governmental problem that needed attention (refer Chapter 4). Studies have emphasised that it is the prevalence of convenience and pre-packaged foods high in sugar, salt, and fat, that contributes to diet-related illnesses and has had an ongoing effect on the health of indigenous peoples (Khalil et al., 2010; Stang, 2009). One gardener (Interview, Group, Nga Whare Waatea Marae, 21 June 2013) succinctly connected issues of convenience foods and pricing to ill-health:

> … the convenient side of things of Maccas or whatever … it's completely stocking our arteries and the salt intake is unreal. When it comes down to māra kai it actually makes you think … it's not only just about that whole 'fruit and vege' side, but it also makes us think about all the other stuff that we buy in a plastic bag, or we buy and … just how much it really is costing, and half of the crap that they put in there.

This respondent's reflections raise important issues around the effect of westernised diets on indigenous health, which have been a focus in indigenous health research. To recap, in Chapter 4 I briefly demonstrated that improving indigenous diets can be linked to the negation of the damage caused by westernised foods through what are essentially decolonising diets (Mundel & Chapman, 2010; Waziyatawin, 2005). As Walters (2012) argues, indigenous community gardens "have helped native peoples to unlearn and overcome food dependency from outsiders, undo the damage of westernised diets and heal the land". While, none of the gardeners spoke directly of decolonising diets, their reflections can be linked to decolonising processes of food provision in urban centres. For example, Lionel (Interview, Lionel, Papatūānuku Kōkiri Marae, 24 May 2012) addressed the colonial control of food in urban centres:

> ... in an urban setting, it's very complicated … 'cause a lot of our people think that good food comes from Pak'n'Save, comes from Progressive bloody Food Stuff, those corporate fullas … see even what happen with Tellies and that aye? All the meat works, it's all just corporate … multi-corporations trying to control our food.

Lionel felt strongly that there is a need to move away from colonial control of food intake for Māori, and this entails marae gardens having to compete directly against fast-food and supermarkets. Interestingly, this view aligns with emerging discourses that characterise gardens as resistance against those who attempt to "colonise their plate". Unfortunately, as I have mentioned elsewhere, there are gaps in my interview data that did not become apparent until after the completion of my interviews. Further discussions on the notion and practice of marae gardens as a grassroots initiative for decolonising diets could have provided some useful insights. However, discussion on this topic was very limited. In hindsight, other gardeners may have had further insights and potential solutions to offer on this important topic which were overlooked.

This section has demonstrated that the everyday experiences and actions undertaken within urban marae community gardens contribute to the development of cultural efficacy. Although understated by many of the gardeners, their discussions reveal indirect and direct acts of local activism. Overall marae food garden engagement comprised of empowering experiences, including decision-making and control that served to enhance the autonomy and cultural capacity of the respondents. The central purpose of the gardens in making an active and practical contribution to Māori family health was reinforced by these actions. Next, I describe the challenging experiences of maintaining and sustaining marae gardens, and the evident paradox for the development of cultural efficacy.

7.4 Challenging experiences for garden sustainability

Notwithstanding my illustrations and arguments in the preceding sections regarding the multitude of wellbeing experiences linked to gardening on marae, all of the gardens were engaged in consistent and ongoing sustainability issues. When asked to describe marae gardening challenges, the respondents primarily identified external-internal or insider-outsider dilemmas affecting the daily maintenance and future sustainability of their gardens. Tracey (Interview, Tracey, Makaurau Marae, 15 May 2012) identifies the issues of money and participation for her garden:

> … it's getting people here, pūtea (money) to run something like this…you know you got to get the soil, you got to get the plants to start off with, unless you're collecting the seed all the time…yeah definitely those two … trying to keep the people here.

Similarly to international community garden studies, the marae gardeners identified significant issues around: external funding; variation in stakeholder expectations and goals; and recruiting and retaining gardeners (Alaimo et al., 2016; Earle, 2011; Ghose & Pettygrove, 2014a). The urban marae gardens

face challenges to their existence and continuation as a daily reality, not only from external forces such as local and national government bodies, but also due to a lack of support, participation and commitment internally from their marae families.

7.4.1 Gardening collaborations, negotiations and contestation

The survival of marae gardens in urban centres is not only reliant on the skills and knowledge of the gardeners (insiders) to maintain the garden, but also on the marae committee and gardeners' efforts to successfully collaborate with external organisations (outsiders) to provide funding support for the gardens. Dependence on financial support from governmental and non-profit organisation grants is a commonly identified feature of community gardens (Firth et al., 2011; Ghose & Pettygrove, 2014b; Lainer et al., 2015). All of the study gardens had experiences of applying to and negotiating with government bodies for financial support, and many of the gardens were the result of past and current collaborations with District Health Boards. Over half of the respondents had direct involvement in securing funding for their garden and they identified several key dilemmas linked to its acquisition and the partnerships required. One common dilemma expressed by these respondents is the dichotomy of striving to ensure independence from outsider funding, but inevitably requiring outsider funding to keep the gardens going. The collective efforts made to ensure the continuation of their gardens, as described by two gardeners from different marae, underpinned the dichotomy of both resisting and reinforcing neoliberalism. The discussions of these gardeners reflect current academic debate regarding radical and neoliberal features of community gardening (Barron, 2016; Guthman, 2008; McClintock, 2013). Below, I demonstrate that marae gardens represent an indigenous example of McClintock's (2013) hybrid of radical and neoliberal engagement (refer Chapter 4).

Community gardens present the duality or double edged sword of alternative food systems and colonial power. Urban marae are largely dependent on governmental funding to support their marae programmes. Elsewhere in preceding chapters, I have described Te Puni Kōkiri Maara Kai grants that support the start-up costs of gardening on marae. I noted that four study marae had utilised this funding for their current garden, whereas the other marae were either previous applicants, or about to apply. Ngahuia (Interview, Ngahuia, Ōrākei Marae, 16 May 2012) described their grant: "We now got 80-tree orchards, 3 tree plants out there. That was through Te Puni Kōkiri. They gave a two thousand dollar grant". Although these grants provided short-term assistance for start-up costs, in my observation this government initiative was not designed to address sustainability issues, or ongoing funding within marae communities. For example, two marae that had received the initial grant were facing difficulties with the ongoing costs of maintenance and did not have marae funds available to support the continuation of the gardens. Meeting costs associated with maintaining and sustaining the gardens was problematic across all of the marae. As Perkins (2009) contends, it is often the already resource poor communities that are most affected by short falls in government funding. When asked if they thought marae gardens were supported financially in their communities, the majority of the respondents answered negatively.

The conflict between complying with funding requirements and meeting the collective wellbeing needs of their families and wider community was difficult to manage according to the respondents. Lionel (Interview, Lionel, Papatūānuku Kōkiri Marae, 24 May 2012) argued that government programmes have their own measurements for wellbeing, "How can you measure those outcomes though? How can you measure somebody who's relieved of … under stress or who's coming out on … how do you measure somebody's happiness?" This point was raised by many gardeners who felt it was not for the government to dictate the outcomes of their health programmes; however, they realised taking this stance would jeopardise funding. In Chapter 3, I demonstrated that governmental, organisational, community, and public policy factors have often served to support and maintain unhealthy behaviours by focusing on the problem not the causes (Hancock, 2011; McQueen, 2011). As Lionel discussed, government targets that focus on measurements for wellbeing cannot improve health for indigenous groups who have differing perceptions of wellbeing. Further, assessing individual health and outcomes in isolation from other factors, such as social determinants, results in short-term or very minor gains in wellbeing (Stang, 2009). While Lionel made only a brief comment on Māori wellbeing measurements, he highlighted a significant concern among health academics and leaders around the constraints or tensions between government and Māori goals and outcomes (Ratima, 2010; Timu-Parata, 2009; Whitinui, 2011).

Despite these concerns, developing external partnerships with local and regional organisations was identified by several respondents as integral to the sustainability of marae gardens. Delwyn (Interview, Delwyn, Makaurau marae, 3 August 2012) commented on the assistance received from outside their marae community which has helped keep the garden alive: "With the ARC (Auckland Regional Council) so we had all these amazing people who had contact with the marae and heard we were doing something with this project so we were keeping them involved and they came out and helped so, that's kind of happened". Three marae had entered into external partnerships at the time of the interviews. One respondent (Interview, Group, Nga Whare Waatea Marae, 21 June 2013) was pleased to have received assistance from an external agency that had not worked with marae previously. She commented that "…the one thing that Bunnings said they haven't ever done was a marae. So this is actually the first time that the Bunnings have actually said 'Wow, let's do it. Let's do a marae'". External partnerships can lead to more effective use of marae and their facilities; however issues often arise about how to maintain the partnerships when ideals of community wellbeing are conflicted.

The current lack of funding for marae gardens had encouraged many of the marae gardeners to become inventive in acquiring their own funds and equipment, including by selling produce to the wider community. Several gardeners had sought help from other urban marae for resources in addition to obtaining advice and knowledge from other marae gardeners. As I mentioned in the preceding section, mobilising to address marae garden challenges generates and develops the cultural capacity of the gardeners. Brian (Interview, Group 2, Ruapotaka Marae, 3 August 2012) reflected on the start of Ruapotaka marae gardens and being resourceful: "We started off [with] nothing, there was no money…there was no funding and I said ok kei te pai [that's good]". It was evident there was autonomy in his experiences when he added: "But what we've achieved here has all

been with no money, it's what we can develop ourselves, what we can pick up and notice working with the soil, and the seasons and the water and when it's dry". Tracey (Interview, Tracey, Makaurau Marae, 15 May 2012) acknowledged that she had utilised family connections to obtain cheap seeds, soil and planter boxes. Among the respondents many commented on the need to find more money and resources and they were proud of their resourcefulness in securing seeds, equipment and funding from other sources.

Nonetheless, being financially independent was a desired goal for the marae gardeners. One respondent (Interview, Anon. 2, Makaurau, 18 July 2012) argued that this financial goal required them to be collectively proactive in making money from the gardens. She added this meant targeting the sale of their produce:

> … but to get there we have to also look at how we're gonna make this financially sustainable … and that means having to sell products … you know, having to plant cash crops that are able to sell .. Bring money back in and then still look at growing super foods like broccoli …

This respondent added that financial security was integral for the survival of their marae gardens, because their marae had limited support funding. For her marae, this meant having to make it clear that the garden must be self-sustaining before anything else. As she explained further:

> … our marae committee, overall, wants the nursery to be able to pay for itself because the only money we get in is through hireage, so there's not a lot of pūtea there to actually give out and especially to keep paying for something that's not paying for itself, so we've had to be quite … I suppose rigid … in our goals rather than go for the touchy feely thing.

When reviewing the future of their gardens, the majority of gardeners wanted the gardens to remain and were cognisant that the gardens need to make money. One respondent indicated that she would like to help initiate dialogue with local restaurants to arrange the sale of marae produce. The end goal for these marae members was independence from government funding, or more specifically compliance criteria.

At the end of this section, I note that despite the potential multiple wellbeing outcomes resultant from marae community garden engagement, marae continue to struggle to support these programmes. I further discuss these issues in Chapter 9 as I consider the role of marae in delivering effective Māori health strategies. While the respondents did not discuss in-depth the financial pressures of maintaining their gardens, I was aware from personal experience and casual conversations that all of the gardens need further financial input. Although marae provide essential programmes, government shortcomings put these programmes at risk. This includes ineffective government relationships that perpetuate funding insecurity, lack of engagement with communities, racism, and power inequalities. In this regard, I align with Alford's (2014) arguments highlighted in Chapter 3. All the marae and Māori

stakeholders would benefit from increased financial support from the government and other funding bodies. In effect, the current non-prioritising and undervaluing of marae as health providers (refer Chapter 5) is contributing to ongoing inequitable Māori health outcomes. More funding with fewer compliance requirements would allow Māori who no longer attend their marae as a result of these ongoing challenges and tensions to return, and continue to participate and benefit from the cultural-collective wellbeing experiences held within.

7.4.2 The internal struggles of marae gardening participation

There was universal agreement among the gardeners that their low numbers was one of their biggest struggles in sustaining their gardens. Marae gardens are reliant on volunteers and the majority of gardeners in this study were volunteers. Of the total 35 gardeners in this study, five were paid staff, six were students, and 23 were volunteers. Some of the gardeners worked in other community gardens – for example, several of the homeless male gardeners also tended a Methodist Church garden. During the interviews and follow-up visits to the marae gardens, it was apparent that all of the marae gardens had issues with participation. This included a lack of ongoing commitment from current and old members, and problems with securing new members. Despite the study marae being located within Auckland, the largest city in New Zealand and with a high number of Māori (Statistics New Zealand, 2013a), overwhelmingly all of the marae were underutilised by their local Māori population. All of the study marae were accessible by public transport systems, apart from Makaurau. Yet, as confirmed by the respondents' conversations and my regular observations, only a small dedicated group of Māori gardeners were actively working the gardens. The low number of gardeners per marae was also reflective of the low number Māori who were active marae members.

As I have discussed, the reasons behind such low attendance for the marae and their gardens are participation issues that can be both simple and complex (see preceding section and Chapter 5). Notably, the location of the gardens on marae can be a major barrier to participation for two main reasons. Firstly, as with indigenous peoples worldwide, Māori have diverse living circumstances and cultural understandings which may affect their confidence or ability to attend marae. The processes of colonisation have impacted the cultural foundations of indigenous peoples including the ongoing effects of cultural alienation and dispossession (Heart et al., 2011). Māori families have experienced a disconnect from cultural knowledge, language and practices (Wirihana & Smith, 2014). Secondly, Māori have also experienced separation from their tribal lands and marae through processes of urbanisation (Tapsell, 2014). Hence, marae are no longer familiar or comfortable environments for all Māori, with flow-on effects for everyday access and utility for many families (Bennett, 2007). As a consequence marae are not universally considered a familiar or welcoming place, but rather a foreign place with restrictive or unknown rules and protocols. I hypothesise that the participation struggles of marae gardens are reflective of the diverse circumstances of contemporary urban Māori. These challenges serve to highlight the difficulties faced by indigenous health systems and the need to provide multiple approaches for the diverse circumstances of urban indigenous groups.

Nonetheless, when the respondents deliberated on the possible reasons for low participation they noted common issues such as cost and lack of time, transport, gardening knowledge and event information. Some of these issues for participation can be attributed to ongoing structural barriers for Māori families. In Chapter 3, I demonstrated that health disparities within indigenous communities are a result of the lived experiences of structural barriers to health, including access and affordability issues as a result of racist health systems and discriminatory practices (Durey & Thompson, 2012; Reading & Wien, 2009). Other gardeners commented on busy urban lifestyles involving sporting activities and other functions in the weekends. Tracey (Interview, Tracey, Makaurau marae, 15 May 2012) expressed the difficulties her marae had in maintaining family participation in marae activities: "Everybody's in their own little world and most of it is the time factor ... 'I can't get there on that day' – yeah I don't … I really don't know…we're sort of baffled". Tracey also noted that many family members had not only lost sight of the important role of marae, but also the role that gardens can play. She commented further: "Everyone is busy, busy, and I don't know, the last thing on people's minds is to learn about gardening yeah…it's how people perceive and how they feel that that's important in their life I suppose". A lack of awareness that their local marae has a community garden open to all community members was noted by one respondent (Interview, Anon. 1, Makaurau Marae, 27 June 2012), who argued that getting people onto the garden was a good start:

> … to those that don't come to the marae as often … I think that's probably because they're not aware. They don't know. Some of them probably will never know that we have a nursery there, or what the nursery does or how it works, but for those of us who are involved and who live around there and who live nearby and keep coming back … that's [the garden] a good thing.

This respondent's argument emphasises the primary difficulty of getting people onto the gardens, as her marae is tribal affiliated and almost completely surrounded by family members of the marae. Despite her marae's strong family connections and locality, non-participation remains an issue for both the marae and garden. Encouraging families to participate in the activities of their local marae has become increasingly challenging, as was noted by three respondents. Tracey (Interview, Tracey, Makaurau Marae, 15 May 2012) posited that the responsibility of the head of the family for encouraging marae participation has changed: "…there used to be one head of the family that would say we are going to do this on this day and everybody needs to come. We don't have that anymore". Several respondents agreed that the dynamics of Māori families have changed and marae and their associated activities is no longer a core feature of Māori lives. Lionel felt more needs to be done to entice new gardeners to attend the gardens and remain involved. He spoke of his ideas for attracting more urban families to the gardens and had recently assisted his wife in implementing a school holiday programme for local youth that included activities based on the television programme *Survivor*. He joked that perhaps marae should have give-away prizes including winning a fridge or a microwave for best gardens maintained by family groups. Other respondents spoke of difficulties in attracting new adult members on to their marae and activities and felt that urban lifestyles created many obstacles.

The discussions with the respondents of their participation struggles revealed an important insight by one gardener. Essentially, if all the factors necessary for effective and appropriate indigenous health promotion are in place – is this reflected in increased participation? Tracey (Interview, Tracey, Makaurau Marae, 15 May 2012) reflected on the participation concerns of her marae and their programmes. First she spoke of a previous garden project on her marae that was not sustained:

> It sort of kicked off with a hiss and a roar and then people sort of dwindled out … lot of it is to do with money … as in trying, for me trying to find enough to keep it going, to keep them interested, having more supply of seedlings to carry on … with the different seasons.

She then reflected her experiences and possible barriers:

> I suppose it's the passion again. If I am really keen for my kids to learn that or for me to do it, I'll find a way, even if one of my cuzzies are going and I'd ask, can you pick us up type thing. Yeah I mean there is lots of challenges are in the world but, some of then I don't think are [laughs] well you know I don't agree that, I can't get there because there is not enough time 'cause it's just how you sort your time…yeah…I mean I suppose with lots [of families], a challenge is always money aye … to be able to put gas in the car to get here…I don't know because our programme we offered, it was all free and we still had … you know we still had all the excuses under the sun.

Tracey highlights many issues related to participation in cities. She makes an important point in noting that even when programmes with the necessary cultural components are free and available on marae, people are not attending. Interestingly, she describes her passion as the driver of her participation. This feature cannot be incorporated in a health programme, but other family members and sociocultural connections may be the key to igniting the spark of passion. The implication of this study finding is that marae gardens are a comprehensive form of indigenous health promotion, but can only be one solution among many.

7.5 Conclusion

Figure 12: Ōrākei Marae 4

Photo 1 – Auckland City Mission māra kai
Photo 2 – Community and whānau gardens

In this chapter I have maintained my central argument that individualised health programmes continue to lack universal relevance for indigenous peoples. Personal factors associated with marae garden participation were rarely discussed by the respondents. The respondents' discussions confirmed that collective experiences and benefits were an essential feature of marae gardening, which had either influenced or were sustaining their current participation. Consistent with numerous other health studies, community gardening was viewed as a relaxing, simple and familiar activity. The simple nature of marae gardening in combination with the associated voluntary and self-directed participation was an important factor according to the respondents, in contrast with many conventional health programmes that are education-focused with predetermined outcomes. Continued engagement in the gardens centred on the multifaceted holistic benefits for family health and important therapeutic land-based experiences within the marae and garden. Many of the respondents were concerned with the current state of Māori health and identified ongoing issues such as poor exercise, food quality, dietary habits and living conditions. Several respondents spoke of first-hand experience from within their families of poor health, including diabetes and obesity. In light of their understanding of the negative effects of local conditions and lifestyle factors on the wellbeing of their own families, efforts within the marae gardens were viewed as a means of offering Māori families with better health choices through improved diets. Hence, healthy Māori families were a foremost concern and goal of their gardening engagement. Notably, working in the gardens was considered by many of the respondents to be an important holistic therapeutic experience that connects Māori to their living environments – physically, socially and culturally.

In Section 7.3, I extended my argument that community gardens contribute to the development of cultural efficacy for Māori. The gardens were seen as providing a physical place for Māori to gather and engage in sociocultural experiences that contribute to their increased cultural capacity. Many of the respondents also noted empowering experiences of decision-making and taking control within their gardening plots. Importantly, these everyday experiences and actions taking place in the gardens served to enhance the autonomy and cultural capacity of the respondents. In parallel with their increased cultural efficacy, several gardeners were engaging in understated local activism to address local health and wellbeing issues. This was exampled in their localised action opposing convenience or fast foods, food insecurity and westernised diets. The central purpose of the gardens was reinforced by these actions, which is to make an active and practical contribution to Māori family health. Last, in this chapter I reviewed the challenges and tensions for marae gardens as a result of insider and outsider contestations. I noted that these experiences can contribute to the increase or decrease of cultural capacity. The survival of all marae gardens is reliant on the respondents and other stakeholders maintaining the gardens with outsider support, and so is also dependant on external organisations providing funding and resources. This paradox underpins the dichotomy of community gardens in both resisting and reinforcing neoliberalism. Ongoing issues of the lack of funding support and undervaluing of marae as health providers are contributing to continued inequitable Māori health outcomes.

All the marae gardens face a tenuous future due to external funding and internal participation issues. The lack of funding for marae gardens has encouraged many of the marae gardeners to become inventive in acquiring their own funds and resource, yet this is problematic because it alleviates governmental responsibility for Māori wellbeing. The insight provided by Tracey at the end of this chapter reaffirms the difficulties faced by indigenous health systems and the diverse circumstances of urban indigenous peoples which require multiple health approaches. Marae gardening is not a panacea for all urban Māori, but it is a comprehensive health promotion activity that develops cultural efficacy – as one solution among many. In my next chapter, I identify and describe the preconditions for Māori wellbeing derived from marae community gardening, as described by respondents.

Chapter 8 Cultivating preconditions for addressing indigenous wellbeing

Figure 13: Papatūānuku Kōkiri Marae 2

Photo 1 – Panoramic view of māra kai (marae complex in background)
Photo 2 – Community member working in the community gardens

8.1 Introduction

In Chapter 7, I extended my argument that individualised health strategies lack relevance for Māori, and marae gardens are more effective because they centre on collective health factors alongside developing cultural capacity. In this chapter, I further this argument, by demonstrating that the associated social features of marae community gardening are important preconditions for Māori health. While improved physical family health is a main outcome expectation of marae gardens, the respondents overwhelmingly identified social factors as a necessity for current and future urban Māori wellbeing. Hence, in each section of this chapter, I demonstrate the main social interactions transpiring within marae gardens contribute to strengthening Māori family connectedness, knowledge and ultimately wellbeing. I show that urban marae gardens provide an opportunity for Māori to engage in essential sociocultural interactions that have become increasingly limited over time for many families (George, 2010; Gillies & Barnett, 2012). These wellbeing experiences and benefits include good nutrition, sharing produce, increased autonomy and capacity, sociocultural connectedness and intergenerational knowledge exchanges (P. King et al., 2015; Taima Moeke-Pickering et al., 2015). Below, I demonstrate many these wide-ranging features which I contend illustrate the effectiveness of marae community gardens for Māori family wellbeing. My argument in this chapter is based on the findings from my discussions with the respondents regarding the wellbeing experiences of social factors linked to garden participation. I argue that social connectedness experienced within marae community gardens is one of the most important preconditions for urban Māori wellbeing. Notably, for some respondents', socialising was more important than the produce or the marae location of the community garden.

In Section 8.2, I review the main social factors attributed to marae community gardens, such as family relationships and intergenerational interactions. Unsurprisingly, the gardens were consistently viewed as an informal sociocultural place than enabled the respondents to spend quality family time together across generations and to build relationships. In Section 8.3, I demonstrate that features of altruism

and productivity are both a gardening influence and outcome for the Māori respondents. Notably, altruism was described in terms of the Māori value of manaakitanga (generosity and care for others). Aligning to my previous chapter argument, many of the gardeners spoke of the social benefits of sharing and caring for others above their own needs. Last, I demonstrate that tending gardens provided a sense of productivity and accomplishment for many of the respondents. These wellbeing feelings increased the respondents' sense of importance and pride within their hectic urbanised lifestyles. Knowledge that their skills and produce were actively contributing to the wellbeing of others also reinforced the respondents' confidence in their collective abilities. Of note, as I further discuss below, my hypothesis from preceding chapters that culture-centred factors are essential influence and outcome of Māori health programmes, was not supported by the respondents. While features of Māori culture were not dismissed or undervalued, the majority of the respondents seldom discussed Māoritanga in terms of importance or practice in the gardens. Nonetheless, as I discuss below, the respondents were drawn to their urban marae and gardens to be among fellow Māori and share experiences, knowledge and skills while engaging in a health activity.

8.2 Social connectedness: being among my own people

As discussed in preceding chapter, the impact of colonialisation and urbanisation has resulted in the undermining of social structures and practices which for hundreds of years had been used to promote and protect Māori health (R. S. Hill, 2012; Kingi, 2007). The relocation of Māori to urban environments has had long-term wellbeing effects as families are isolated from their cultural foundations, living in poverty, and facing barriers of access to health services (Came et al., 2016; Timu-Parata, 2009). Similar to the international experiences of indigenous families, urban living for Māori has often resulted in a disconnect from important sociocultural resources and networks as families have become "dispersed and relatively invisible" (Wendt & Gone, 2012a, p. 1029). Community gardens literature has demonstrated that indigenous gardens can have an important role in reconnecting gardeners to their immediate and wide family members, also their culture and living environments (P. King et al., 2015; Kingsley, Townsend, Phillips, et al., 2009; Mundel & Chapman, 2010). In New Zealand, as I show below, marae community gardens offer many sociocultural benefits as a medium for passing on family and cultural knowledge, alongside developing cultural-collective values such as sharing and caring for each other.

In Chapter 4, I showed that community gardens can encompass numerous social benefits for both indigenous and non-indigenous gardeners. Expanding social networks is proven to be a leading influence or motivation for garden participation (J. R. Brown, 2012; Firth et al., 2011; Kingsley, Townsend, & Henderson-Wilson, 2009). Similarly, all of the respondents referred to their gardens as a place for them to come together and connect with other family, tribal and marae members within their community. In urban centres, indigenous peoples involvement in community gardens can be linked to social opportunities for fostering new relationships and strengthening family ties and networks, while at the same time developing cultural connections (P. King et al., 2015; Wen Li et al., 2010). In total, all of the respondents identified positive social outcomes that aligned to current community garden

research, including reaffirming relationships and engendering appreciation of family (Carney et al., 2012). These social outcomes were succinctly described by one gardener (Interview, Group 1, Ruapotaka Marae, 27 June 2012), when she highlighted the benefits of gardening for her family and community members:

> The benefits of having a garden? Everything - from getting together to put that garden down. I know the whānau that are involved in the garden … The connecting, the social side of all of that, that's the part I love … The marae whānau are already kind of benefiting from what's happening there.

Other respondents spoke similarly of social benefits, specifically their enjoyment of socialising while gardening. Certainly, socialising with family members was universally acknowledged and highlighted by all of the gardeners as the most significant wellbeing benefit of marae gardening.

The high priority of socialisation as a precondition for wellbeing among the respondents emerged as a study finding contrary to my preconceived hypothesis of the influential role of marae and associated sociocultural experiences. Prior to the commencement of my interviews, I had anticipated that the cultural benefits of marae in terms of increased Māori language, knowledge and identity (belonging) would be attributed as the most significant benefit and outcome of marae gardens (see further section 8.2.2). Indigenous health studies have prioritised cultural processes and development as fundamental to effective culturally relevant approaches conducive for indigenous wellbeing (Dockery, 2010; Goodkind et al., 2015; Hartmann & Gone, 2012). Nonetheless, the gardeners' seldom spoke of their increased cultural awareness or credited this feature as an important outcome of their marae gardening participation. Some respondents inferred that socialising or being among fellow Māori was more important than the health activity or the marae setting. For example, one of the homeless male gardeners (Interview, Homeless Men's Group, Ōrākei Marae, 24 May 2012) revealed that he would be happy to garden at any location. His enjoyment was derived from being with his 'street' family and providing food for City Mission. Aside from the gardens, this respondent did not participate in any other health or cultural activities that took place on the marae (see further Chapter 9).

Notwithstanding, by placing gardens on marae, urban Māori are provided with an opportunity to socialise within a culture-centred setting. As I argued in Chapter 5, marae can provide Māori with a vital source for the development of cultural connections and abilities, because they are cultural and social gathering places. This is supported by King's (2015) study in which he identified marae as a 'Māori space of being'. Connecting with other gardeners and the social benefits of marae gardens was illustrated by one respondent (Interview, Group 1, Ruapotaka Marae, 27 June 2012), who described the collective wellbeing outcomes of gardening:

> … it's all beneficial, it's all about the whole … new people being a part of the group, sharing each other's stories … I think about a garden at the marae and a group of people doing it … I'd imagine that we'd be working the ground together sharing each other's stories, sharing what we need to share.

The collective attributes of gardening described by this respondent serves to highlight the expectation of social benefits and outcomes from marae gardens. All the gardeners spoke of their enjoyment of being in the company of other gardeners in their urban environment and their ongoing aspirations to entice more family members to work with them. Interestingly, one gardener argued that the only reason she tended the garden was to socialise and relax with other family and marae members. As I illustrated in Chapter 5, the colonial 'pepper-potting' housing policy for Māori in urban centres has resulted in divided and scattered families (R. S. Hill, 2012; Waitangi Tribunal, 2011). Consequently, aside from a small group of gardeners who lived on papakāinga (communal Māori land) surrounding their marae, the majority of the respondents no longer (or have never) lived within kinship-based communities. Hence, the marae community gardens provided the respondents with a culturally familiar place to meet and socialise while engaging in a mutually beneficial activity. As discussed in previous chapters, these holistic therapeutic features of gardening contribute a sense of belonging and to the development of cultural capacity and confidence of Māori.

A small number of respondents argued that the marae gardens offered a place to build social (family) relationships and counter urban social isolation. Indigenous studies have shown that building and strengthening family connections serves as a protective factor against a range of negative forces such as health issues, substance abuse, mental health issues and social isolation (H. J. Brown et al., 2012; Goodkind et al., 2015; Stuart & Jose, 2014). As previously mentioned, these holistic health issues can be attributed to the ongoing impacts of colonisation and structural barriers that have affected the social and cultural foundations of Māori families (refer Chapter 3). Hence, many of the gardeners were concerned about the isolation of Māori family members in the city. Two gardeners were particularly concerned about the isolation of elderly from their immediate family and wider tribal family. They spoke of koroua (elderly) living on their own and staying or being confined to their houses, often receiving little or no help from family or services. Delwyn (Interview, Delwyn, Makaurau Marae, 3 August 2012) argued that her concerns extended past social isolation of elderly Māori and also to physical isolation. She clarified: "…we're not a kissing-hugging society anymore, there's [not] a lot of this going on. So they don't have that physical kinda touch, that presence … so that's really important too, give them a hug "Yay we're gonna do this today". Active participation in the gardens provided valuable social and physical support for the gardeners while also acting as a counter-action for urbanisation by reducing isolation and increasing family and cultural connectivity (Snyder & Wilson, 2015). Importantly, some respondents noted the 'type' of health activity hosted by their urban marae often had less importance than the social experiences that evolve.

Two respondents indicated the necessity of encouraging new members to participate in marae gardens and to enjoy wide-ranging social experiences. The respondents' (Interview, Group, Nga Whare Waatea Marae, 21 June 2013) concurred that new members brought fresh energy, perspectives and ideas to the garden. One of these gardeners also spoke of the benefits of socially coming together: "it has really brought about an excitement that's really kinda unexplainable because it is exciting that we're gonna have this amazing garden here at the marae … it's brought different areas together, people that haven't even been on a marae before". The excitement was not only

based on new faces but the new conversations and friendships occurring around the garden. Delwyn (Interview, Delwyn, Makaurau Marae, 3 August 2012) argued that while actively working in the garden and "everybody's got a shovel and a spade" people can take part in everyday ordinary conservations. It was healthy not only to physically garden but also to take part in conversations and debates when gardening, because the underlying outcome of these social exchanges was valued companionship (B. Turner, 2011). Similarly, the student group (Interview, Student Group, Manurewa Marae, 24 October 2012) of horticulture gardeners described closer social connections as an outcome. They agreed that in their everyday lives outside marae they would not have taken the time or effort to speak with each other, nor sit next to each other and share food. The benefits of their gardening course on the marae were identified as a good mix of "friendships and communication", and these social aspects had supported a feeling of being "pretty tight" among the group. As described in Chapter 7, I suggest that these ordinary conversations and social interactions held around gardens can also lead to collective deliberation and discussion of current local issues, and then strategising workable solutions (Milbourne, 2012). In the next three sections, I further explore some of main social features attributed to gardens by the respondents, including connecting with family within an informal sociocultural setting, to engaging in learning experiences through intergenerational interactions.

8.2.1 [re]Connecting with family

To recap, community gardens provide a space for family members to meet and strengthen their social connections (H. Anderson & Kowal, 2012; Carney et al., 2012; Wen Li et al., 2010). Studies have shown that families gardening together contribute to a sense of togetherness and enable a sense of engagement and cohesion by having a place to spend quality family time and to build relationships. Being among family while gardening and knowing that the marae members were benefitting from their efforts was a concurrent theme in the respondents' interviews. A distinctive quality of marae gardens is that fellow gardeners are often family members, including extended tribal members. With the exception of two marae gardening groups comprised of homeless gardeners and student gardeners, all of the remaining marae respondents developed and worked in the gardens with at least one family member. On one marae (Makaurau Marae), all of the six respondents were close family and extended family members. Unsurprisingly, this group spoke the most about the importance of connecting with family around the gardens. The majority of this respondent group lived on or near their papakāinga surrounding their marae. Their marae garden was described as an enjoyable family environment, as described by one respondent (Interview, Anon. 2, Makaurau Marae, 18 July 2012): "…it [marae gardens] creates a real whānau (family) environment, everybody enjoys each other's company, so you get strength out of that … it's all the touchy feeling things that go with feeling good". Kaya (Interview, Kaya, Makaurau Marae, 10 October 2012) from the same marae garden and the youngest respondent of this study (15 years), admitted a leading motivation for her garden participation was the opportunity to work with her cousins; otherwise it would be "boring".

Family factors were also the motivation for one of the homeless gardeners (Interview, Homeless Men's Group, Ōrākei Marae, 24 May 2012) who spent most of his time on the streets, but gardened within his inner city tribal marae. He stated that "Just knowing that my whānau lives around here, [makes me] look forward to coming out here and looking at the sceneries and being here with the family". He also

viewed the gardens as a means to provide food for both his homeless family and his marae whānau. In this regard, the garden was one of the few places that this respondent could interact and reconnect with family members, and also fulfil a sense of purpose by giving to others in his urban living environment (Christensen, 2013) (see further section 8.3). Other respondents noted that the marae and the gardens also provided a venue that facilitated meeting new family members or extended relations. Tracey (Interview, Tracey, Makaurau Marae, 15 May 2012) articulated that for her it was the ability to connect with new family on the gardens that contributed to her wellbeing and gardening motivation:

> I've met … a lot of relations that I actually didn't know quite well or actually didn't know because they just joined up, you know, put their hand up to do something that's been involved in the nursery. That side of it too has been you know unexpected and really…. you know good for me.

Tracey also commented that many of the young people of her marae had grandparents that had passed away which placed an onus on her and other family members to pass on gardening knowledge (see further below). Yet, it is important to note that not all the respondents sought the company of other family members on the gardens. Two respondents were clear that they enjoyed gardening alone on their marae away from family as a form of respite. As one respondent admitted that gardening was their time to 'get away' from whānau, and another respondent added that it was time to 'do their own thing'. An elder gardener (Interview, Grant & Nic, Ōrākei Marae, 10 October 2012) commented that being alone in the garden was his quiet alone time for reflection, "I'd be sitting there for about an hour just watering my garden by myself like you're saying you can do some really deep thinking because you're connecting with Papatūānuku". In this regard, the marae gardens provided the respondents with a choice of interacting with other family members or spending some therapeutic time alone (Milligan, Gatrell, & Bingley, 2004; Pitt, 2014).

Alongside immediate family connections, studies show that indigenous community gardens provide a means of connectedness to ancestors (Stronik et al., 2010). The respondents also spoke of gardening as an activity that spanned and connected families to the past and present, and that fond memories of gardening with grandparents played an influential role to their gardening. This is consistent with studies that link positive childhood experiences with gardens to influence and promote positive attitudes toward gardens as adults (Gross & Lane, 2007; Lohr & Pearson, 2004; Pleschberger, 2014). Respondents spoke warmly of an upbringing that included gardening with their parents and grandparents. They also made social connections with their memories and their current gardening involvement. Gardening enabled the restoration of past experiences and memories for one respondent (Interview, Group, Nga Whare Waatea Marae, 21 June 2013), who explained that "since māra kai has come about that's 'the restored memories' that are completely coming back to me about that stuff, and so … just how awesome it was seeing my nana at the bench when my grandfather would bring those potatoes in and they're covered in dirt". Similar memory links were described by several respondents, and that gardening was a vehicle for tapping into past enjoyable family memories that are often taken for granted or forgotten in their busy life styles.

Although only a small number of the respondents spoke of their gardening experiences on their tribal marae in their childhood, many respondents described memories of working on home or communal gardens. For example, Ngahuia (Interview, Ngahuia, Ōrākei Marae, 16 May 2012) recalled her family members at work in the gardens: “I use[d] to watch my nannies in the garden and their bums were always up and their backs …you know, bums up back down, and it was like … if you work hard you get something good from it”. Another respondent (Interview, Group, Papatūānuku Kōkiri Marae, 27 July 2012) recalled a poignant upbringing with their grandfather and the benefits of learning with him:

> [I was] brought up by my grandfather from the age of three. I think he died when I was eleven, but brought up by him … [He] taught me ... the importance of growing your own kai and I enjoyed it very, very much ... they also planted by the moon and that was awesome, did the fishing by the moon as well on and off following the moon so yeah, brought up old school and that stuck with me as well.

This respondent’s reflections highlight the benefits of gardening with family, in particular, that working with grandparents facilitates the transmission of traditional knowledge and practices. The ongoing consequences of colonisation has resulted in the fragmentation of Māori from not only physically from their land, but also the means of knowledge transmission opportunities to witness or experience working alongside cultural experts (McKerchar et al., 2014; Taima Moeke-Pickering et al., 2015). As demonstrated in Chapter 5, these consequences have also lead to the weakening of Māori cultural foundations and the current engagement of Māori with their marae (Tapsell, 2014). Nonetheless, several gardeners were interested in traditional Māori produce and had made efforts to learn and grow their own within their gardening plots. Research results highlight that growing traditional foods is important for nutritional wellbeing (McKerchar et al., 2014; Wham et al., 2012). As I showed in Chapter 4, over time as the customary practices associated with harvesting, growing and preparing traditional foods diminished, so too has the associated knowledge base and practices(Forster, 2011). In New Zealand, recent studies exploring revitalising traditional kai found that marae gardens are an important forum for learning and sharing methods of growing traditional foods and improving food security for Māori (McKerchar et al., 2014; Taima Moeke-Pickering et al., 2015). For some respondents, gardening was viewed as a way of learning and producing certain types of produce commonly used in traditional Māori feasts such as kamokamo, pūha and certain types of kūmara and Māori potatoes. I observed on several marae that the gardeners had planted traditional Māori produce according to traditional methods such as Maramataka[22]. These respondents spoke of their desire to experiment and grow produce that was culturally familiar. For some of the respondents, traditional foods were a fond connection to the past and childhood experiences in the gardens. The marae gardens presented an opportunity to [re]learn traditional skills and knowledge for the gardeners, and the respondents that spoke on this matter expressed that this was an important feature specific to marae gardens.

[22] Māori lunar calendar - a planting and fishing monthly almanac

Marae gardens presented invaluable opportunities for the respondents to connect and socialise with other family members and strengthen family ties. Interestingly, while some studies have shown that community gardens can also function as sites of family conflicts (Andrew Hume et al., 2013; Wen Li et al., 2010), none of the gardeners spoke of family tensions occurring in their gardens. Wen Li's (2010) study highlighted that garden tensions can arise due to power negotiations and issues of control within family relationships, and Hume's (2013) study of remote aboriginal gardens showed that family disagreements had led to denied access for family members to the garden and its produce. The only tension raised by a small number of respondents was dissatisfaction with family members that chose not to participate in garden or marae activities (refer Chapter 7). Notably, I did not ask about family tensions within gardens, which may have resulted in this lack of discussion. Nonetheless, family interactions were consistently described by the respondents to be a distinct benefit of marae garden engagement.

8.2.2 Informal sociocultural experiences

In Chapter 4, I demonstrated that that community gardens, in particular their informal nature, provided a relaxing space for social interactions and experiences. Studies showed that community gardens are informal gathering spaces that are socially inclusive and incorporate informal methods of learning (J. R. Brown, 2012; Firth et al., 2011; Milburn & Vail, 2010). The informality of marae gardens was described by the respondents as conducive to socialising among fellow Māori. As Wyn (Interview, Wyn, Nga Whare Waatea Marae, 21 June 2013) provided an insightful reflection that socialising was easier on gardens, because they incorporate a level playing field where everyone was equal within this informal social setting. Gathering together and working the gardens was more than just producing food, according to Wyn (Interview, Wyn, Nga Whare Waatea Marae, 21 June 2013). He argued that gardeners need to "make a very conscious effort to share those [important] moments with whānau, share a kai, to drop the labels and different personas that we all carry, just sit around the table as whānau". Garden involvement meant sharing beyond the plots and included going to the dining hall on marae and eating together (see further Section 8.3). Shared meals among indigenous peoples are important opportunities to engage in face-to-face social interactions and learning experiences (Hardin, 2015; Mangadu et al., 2016). New health behaviours for indigenous peoples can be learnt and shared within these collective experiences, such as providing healthier fresh foods and less processed meals (Hardin, 2015; Mundel & Chapman, 2010).

Several respondents expressed empowerment of their experiences through transmitting their expertise to others and learning from other gardeners (Poulsen et al., 2014; Stronik et al., 2010). Ngahuia (Interview, Ngahuia, Ōrākei Marae, 16 May 2012) elaborated on skill sharing within the gardens: "it's sharing knowledge with others; reading, I do a lot of reading, plus I took on the horticulture course. Yeah so I completed that last year. I've learnt a lot from that and a lot from just talking to people from all over". Another respondent (Interview, Group 1, Ruapotaka Marae, 27 June 2012) spoke correspondingly: "The main benefit I've seen is with the group is the participation and the ability to accept the different ways of doing things rather than you do this and you do this and that's how you get your vegies to grown, and just the alternative ways of going about doing things in the garden". One respondent also highlighted her willingness to participate in marae activities and to take

advantage of other marae members' expertise. Accessing and witnessing experts or role models in action was an important aspect of mutual skill sharing for the respondents (Halbert et al., 2013; Teig et al., 2009). Face to face interaction with other experienced gardeners was of particular importance to one respondent (Interview, Anon. 1, Makaurau Marae, 27 June 2012):

> Just gaining knowledge cause I wouldn't have got that anywhere else, oh I could have gone to a book and could have read it in the "Ace gardening book" but I don't learn as well like that so hearing him, watching him, and doing it with him, was much more beneficial and it's like cool I'm gonna go home and do that right now which was really good.

This form of interpersonal experiential learning was an important feature of community gardening according to several respondents. Community garden studies have shown that indigenous peoples prefer this form of learning, in particular when it is immersed into their day to day lives (Lombard et al., 2014; Stronik et al., 2010). Brian (Interview, Group 2, Ruapotaka Marae, 3 August 2012) spoke of the benefits of working on an urban marae garden in terms of marae togetherness and being part of a community that shared knowledge and participation in activities. He explained that tending the gardens involved approval and appreciation by other marae members of this work and his capability. Reviewing his garden work and contributing knowledge for members served to increase his sense of community, which he related to wellbeing due to outcomes such as less stress and also less visits the doctor. Notably, several respondents displayed a wide range of expertise and knowledge of gardening practices, and all were happy to share their knowledge with others. Some gardeners had similar aspirations to extend their gardens beyond their current plots in an effort to encourage more participation from other family members and by doing so extend the current knowledge base of traditional and conventional gardening practices.

In terms of development of Māori language skills through exchanges or learning experiences within the gardens, once again this Māoritanga subject was seldom discussed. This included a notably lack of conservations regarding Māori language and knowledge exchanges. I observed during my interviews and follow-up visits that all of the gardeners had varying abilities of Māori language (Te Reo) and knowledge, as this was evident in their utilisation of Te Reo and Māori concepts while describing experiences in their gardens. Yet, none of the respondents identified cultural experiences with other gardeners as a means of strengthening their cultural knowledge and abilities. Based on this discussion gap, it was difficult to ascertain the extent of informal processes of learning Māori culture and practices within the gardens. Numerous studies have indicated the importance of everyday and informal cultural learning experiences (Corntassel, 2012; Wexler, 2009a) not only for indigenous wellbeing, but also cultural reinvigoration (Gillies & Barnett, 2012; Goodkind et al., 2012). In this regard, I surmise that community gardens facilitated informal methods of learning Māoritanga, based on observations, yet could not be identified as a high level cultural learning activity. Notably, I acknowledge this 'ripple effect' from my unspecified questioning of the cultural benefits or experiences within marae community gardening. Nonetheless, while the respondents did not speak explicitly of their cultural experiences, however, several emphasised the cultural importance of marae in terms of

how it (re)connected them with fellow Māori and with Māori practices (Bennett, 2007; Tapsell, 2002). The informal setting of the garden provided a means of accessing and enabling cultural interactions between gardeners and marae members including experts and elders, yet the exact outcomes remain relatively unknown (see further Chapter 9).

Although descriptions of cultural traditions practised within marae gardens were seldom discussed, one marae gardener provided a brief insight into her cultural practices within the gardens. Rango (Interview, Rango, Mataatua Marae, 24 October 2012) explained rituals of prayer and gardening:

> … you need to do a karakia (prayer) for all those things that you do here … I said "if you do a garden, you start off with a karakia". That's what we do, we start off with a karakia. Which is everything we do - is all in karakia, when you pull them out [produce], it's a karakia, it's gotta be done. I will always believe it see, you know, when it's done you, thank you and, you thank Papatūānuku and Ranginui and we always thank them for bringing all of those things here.

This marae member and gardener further explained that she was willingly to teach other members both of gardening and associated cultural practices. Importantly, while Rango was one of the few gardeners to review her current cultural practices within the gardens, again this was not reflective of the other gardeners' lack of application or practice within the gardens.

8.2.3 Intergenerational knowledge exchanges and experiences

A consistent topic among the respondents was the necessity of intergenerational exchanges within marae gardens as a means to preserve knowledge and strengthen relationships across all age groups (George, 2010; Gillies & Barnett, 2012). Older gardeners or elders can play a varied and pivotal role in community gardens connecting across generations to exchange knowledge of gardens and culture. As Gendron (2016) argues in her study of indigenous foods exploration and re-vitalization in Saskatchewan, elders pass on extensive tribal knowledge and practices which can prompt intergenerational interest to learn more about harvesting, storing and preparing traditional foods. This notion was relevant to the marae gardeners who acknowledged the value of kaumātua on marae for sharing knowledge of gardening and cultural practices. According to Tracey (Interview, Tracey, Makaurau Marae, 15 May 2012), the presence of kaumātua on marae can provide gardeners with a source of traditional knowledge which should be utilised more, "it's been tapping into our kuia and kaumātua … [who are] very knowledgeable on different things". She also illustrated intergenerational experiences that can take place between young and old gardeners through shared activities and stories: "…the kaumātua …their stories will come, so that's the benefit there from them and the story behind why they did that and why their mother or father told them to do it that way". Another elder gardener (Interview, Grant & Nic, Ōrākei Marae, 10 October 2012) spoke of Māori concepts related to gardening and viewed gardens as a facilitator of cultural lessons for younger members. He explained:

> … what I'm saying is instilling it at a young age what Papatūānuku (Earth Mother) is, who Tānemahuta (Forest God) is, who Tangaroa (Sea God) is and to get them to

> respect Tānemahuta, Tangaroa, Papatūānuku. Then they get that affiliation with the whenua (land) they get that affiliation with Tangaroa so they're not gonna be out on the boat chucking plastic over for example chucking their drink bottles over the side. My kids will never do that, they are not dropping rubbish on Papatūānuku. It's getting our kids to go affiliate with our atua Māori (Gods) and it becomes more meaningful to them and if they have those experiences when they are young then certainly when they grow up and they're gonna be at my age and all that sort of thing. They're gonna know about Tangaroa, they're gonna know about Tānemahuta and I think that's where it's at the key to it all - is teaching our kids about māra. Teaching our kids about our affiliations and then from there we'll make the change.

This respondent's summary of his teachings with his family around the gardens provides an important example of the depth of knowledge that can be learnt within the informal setting of marae gardens. The gardens provide a physical site for environmental lessons alongside cultural lessons, which have become increasingly significant in urban centres where these opportunities have decreased for many families (see further Chapter 9). The passing on of traditional knowledge to younger generations was affirmed by several gardeners as a main influence for gardening. This notion is supported by studies that highlight the strong emphasis indigenous cultures place on family relationships which is strengthened by sharing knowledge, teaching and providing company for younger people (Mangadu et al., 2016; Ricciardelli et al., 2012; Stuart & Jose, 2014). Theses beneficial outcomes were clearly articulated by one gardener (Interview, Anon. 2, Makaurau Marae, 18 July 2012) who encapsulated the views of many gardeners when she spoke at length about her involvement in the gardens:

> I just want my grandson to have a healthy upbringing, I want him to know … to get his hands dirty and to grow things. I want … and I wanna be there to be able to teach him so … which means that my lifestyle has to change … we're kinda investing our time with our kids but also bringing in their … the best teachers are their parents and their grandparents, and that's the idea of it, that's what we hope anyway … we think that's gonna make it work, invest a whole shit load in to their kids and then work with the parents.

She added:

> …we've got our Kōhanga Reo, they have their own special boxes that they've built to grow their kai, so when they come in and do theirs their parents are with them … looking at it backwards, it's our kids that are actually teaching their parents the relevance of having the garden, and that's what … that's our strategy.

Many respondents felt they had an obligation to teach their grandchildren and pass on gardening knowledge and practices. Gardening with younger family members was viewed as an enjoyable teaching method and an invaluable investment of their time and efforts. For example, Rango (Interview, Rango, Mataatua Marae, 24 October 2012) gardened on a marae with a Kōhanga Reo,

and described her interactions with under five year olds in the centre, and that she encouraged them to garden with her so she could share knowledge of both gardening and Māori concepts. She (ibid) explained her engagement with young children:

> [We] spending time talking about Papatūānuku, me a rāua tamariki (and their children) … Ranginui … everything about that. It … it brings the history … the story, of our kai … māra kai and I think it's really good for teaching the young ones how to do it … eating, I think what they should do, if they're eating, is to cut it. If when it's ready, cut it … put it on the side or give it to each child to take something home, that would be good.

This respondent along with other gardeners viewed their garden participation as a means of giving back to the next generation and inspiring a love of gardening alongside providing food for their families. Five respondents commented that the value of sharing knowledge with their grandchildren also enabled younger family members to produce their own food and limit buying shop vegetables (refer Chapter 7). In this regard, the respondents were contributing to the empowerment of their families to control and maintain their food quality and choices (Milburn & Vail, 2010; Okvat & Zautra, 2011). As Ngahuia (Interview, Ngahuia, Ōrākei Marae, 16 May 2012) stated that teaching children should start young: "That's where it's got to start, I think …is from the mokopuna (grandchildren), they're the holders of the knowledge, and there are the ones … and it's actually…we'll see more kids at our planting days than we do adults". This gardener was involved in her marae-initiated community planting days, overseeing the planting of natives in select areas in the city to restore native areas. She was pleased and encouraged that involvement of young children and families in native planting days was increasing.

Intergenerational teaching and learning experiences within community gardens for indigenous people has shown to be an important means of preserving traditional horticultural knowledge and first-hand experience with food production (Northrop et al., 2013; Walter, 2012). This was highlighted by several respondents as a significant benefit of gardening on marae. Dawny (Interview, Kuia, Whaea Dawny & Mere, Makaurau Marae, 18 July 2013) identified her father as both a gardening teacher and provider for her community: "I know my dad used to harvest all his whatever he had and they just went to the marae cause we were so close, we lived across the road …he…we also…he also taught us like in my generation like my brothers and sisters … we all have gardens … I still have a garden now". A current dilemma revealed by respondents was having fewer opportunities in their urban residences for these mutual skill-sharing and intergenerational exchange opportunities to occur. Several gardeners argued the marae gardens should be utilised as a place to learn valuable skills and information and then apply those skills in home gardens. Tracey (Interview, Tracey, Makaurau Marae, 15 May 2012) reviewed her increasing skills and the benefits of applying them to a home garden: "I think that what I take home … rubs off on to my own family at home, and get them interested and show them how to you know garden and grow your own kai". A student gardener (Interview, Student Group, Manurewa Marae, 24 October 2012) also enjoyed sharing his new knowledge within his family:

> I've been learning what goes with what and when certain things go in, and I got my step dad up the road, and then across from him I have a cousin. I got my step dad doing one thing and I'm like "No, no, no, don't do it like that. You don't do this". And I'm telling them how, to correct him and I'm across the road saying "No you don't do it like that, you do it like this.

For this gardener, his acquisition of gardening knowledge meant also that his family was learning and experimenting with growing produce at home. This showed that learning and teaching of new skills among the respondents was not limited to the marae gardens. Several respondents also expressed an interest in learning about new gardening methods, organic horticulture, and waste management. Increasing the knowledge base of the gardeners involved seeking external expertise from outside the marae. One respondent (Interview, Group 1, Ruapotaka Marae, 27 June 2012) acknowledged seeking advice from external sources: "they've got a garden up in Ōrākei and it has been going for a while … and they've got a lady up there and she's showing everybody alternative ways of doing stuff in the garden … and that was interesting to me". Other respondents also commented on beneficial encounters with other gardeners from their wider community who had visited the gardens to share expertise on specific garden procedures.

Encouraging more elder participation on the gardens was identified by respondents as a current issue. Their concern was based on the potential loss of knowledge regarding Māori traditions and skills in both growing and sourcing food. Loss of traditional knowledge due to the demise and reducing numbers of indigenous elders is consistently reported as a major issues within food sovereignty literature (Taima Moeke-Pickering et al., 2015; Skinner et al., 2016). One respondent (Interview, Anon. 2, Makaurau Marae, 18 July 2012) spoke directly about this matter, commenting "…all that knowledge that my grandfather had and that was introduced to me, my children have missed out because my father didn't practice it and then it became… as you can see, I haven't got a garden so it's the practice dying with them". Another respondent (Interview, Grant & Nic, Ōrākei Marae, 10 October 2012) noted the potential loss of knowledge regarding traditional food.

> …things that passed down from generation, see we know where all the watercress catches are here. There are only a few of us that know them because we were the gatherers and the others weren't gatherers. Well they still don't know till this day where the local watercress catch is but we do we've always been like that we've always gone and picked puha and watercress.

These issues regarding loss of knowledge resounded for other marae, as Delwyn (Interview, Delwyn, Makaurau Marae, 3 August 2012) pointed out that over the last four or five years their marae had seen several koroua and kuia pass away, and with them so too essential knowledge. Importantly, the respondents' concerns regarding the loss of knowledge of elders provides a useful argument supporting the role of marae and gardens as a social gathering place for Māori. In particular, elderly Māori who as important holders of knowledge can interact with marae members of all ages and impart their knowledge. This also emphasises the importance of situating and supporting health promotion on

marae, because these experiences are more likely to occur where young and old work together. The informal space of the garden provides an ideal environment for combining a health activity with learning about Māori culture and the tangible connection between land and wellbeing (see further Chapter 9).

This section has reviewed social factors identified by the respondent that contribute to Māori family wellbeing. As discussed elsewhere, these wider social benefits have an effect on the social and cultural wellbeing of Māori (M. Durie, 2012; Kingi, 2005). These sociocultural factors impact the cultural capacity and wellbeing of Māori by enabling a greater psychological resilience from distressing mental and emotional conditions (Muriwai et al., 2015). Increased family connectedness also reinforces cultural-collective relationships and the positive effects these relationships have on wellbeing. The considerable discussions of social connectedness by the respondents' supported my earlier argument demonstrated in Chapter 3, of the need for simple holistic health promotion. This includes the development of less structured programmes that prioritise cultural-collective outcomes, such as improved family networks, which are more applicable and appropriate for indigenous communities. Hence, health education focused or physical measurement outcomes should not be a standard requirement for indigenous health promotion and health goals. Instead programmes outcomes of that prioritise improved social connectedness can have more relevance. Notably, the general consensus of the gardeners was that marae gardens had an important social function alongside the health activity of gardening, specifically as a Māori place for socialising among Māori in their city environment. Fostering new and old social relationships within community gardens contributes to social capital and the establishment of trust among the gardeners (refer Chapter 4) and important to this study is that these features can enable and empower the gardeners to work towards common goals including a healthier community (Firth et al., 2011; Lainer et al., 2015; Milbourne, 2012). Thus, building social capital within community gardens on urban marae can contribute to the development of cultural capacity. Next, I review the secondary preconditions for wellbeing identified by the respondents involving sharing experiences and productivity within the marae gardens that developed their cultural capacity as the respondents contributed to wellbeing of others (refer Chapter 2).

8.3 Altruism and productivity: sharing and caring within the gardens for others

Figure 14: Ruapotaka Marae 2

Photo 1 – Māra kai at the rear of Ruapotaka marae (2011)
Photo 2 – Māra kai in front of the wharekai (2012)

In the last section of this chapter, I review the remaining two main preconditions for Māori family wellbeing described by the respondents. Alongside the importance of socialising among family, marae and community members the respondents identified that knowing that they were helping others was a significant outcome and collective benefit of marae gardens. As previously demonstrated in Chapter 4, sharing food produce in indigenous communities is linked to customs and traditions of sharing within tribal groups to ensure very few people went hungry (Rudolph & McLachlan, 2013; Sebastian & Donelly, 2013). As Skinner's (2016) study regarding food insecurity and urban indigenous peoples showed, food sharing including practices of preparation and eating remains important among indigenous peoples because it promotes community and social cohesion, as well as physical and emotional health and well-being. By producing food and sharing food, the respondents spoke of similar notions of increased emotional wellbeing from feelings of self-worth and accomplishment. For other gardeners, sharing time produce and efforts was linked to their values and identify as Māori. As Brian (Interview, Group 2, Ruapotaka Marae, 3 August 2012) argued that the gardening among families can be considered as a vehicle for connecting people to a Māori philosophy of caring and sharing with each other. Two elder gardeners (Interview, Kuia, Whaea Dawny & Mere, Makaurau Marae, 18 July 2013) spoke similarly and of their aspirations for their marae garden that "it brings you back to sort of whānau kinda situation that we, that I used to like anyway, where we all helped to harvest and so you all got a piece of the cake you know … we all helped to weed, we all helped to … this is what we are trying to do out there". Growing food to share among family, marae and community was widely discussed by all the respondents. The sociocultural environment of the marae reinforced the notion that the gardens were for the benefit of everyone involved (see further Chapter 9). As one gardener (Interview, Group, Papatūānuku Kōkiri Marae, 27 July 2012) described the personal and collective benefits of sharing produce among other gardeners including family members: "I don't really grow it for myself, I grow it for everyone else and it's just … I just feel good giving, giving something back, you know?". This gardener emphasised that sharing was a significant motivation for gardening.

Another gardener (Interview, Homeless Men's Group, Ōrākei Marae, 24 May 2012) from the homeless men group was motivated to tend his marae garden knowing that his produce was contributing to food parcels for his street families, and he commented: "cause I know some of our whānau are getting some of those food parcels, so you know, we are helping our whānau and others". Like others, Delwyn observed that sharing and giving away food made them feel good (Interview, Delwyn, Makaurau Marae, 3 August 2012): "it's about whatever you got …swap it, but even then it's the sense of giving. If you've got an overflow then give it. The best thing … you know it's fantastic to be able to say "come and get some fresh eggs" and "I've got some plums around the back". Two elder gardeners (Interview, Grant & Nic, Ōrākei Marae, 10 October 2012) commented that according to Māori values the purpose of gardens regardless of location is to share the produce: "…whether it's in the back house of somebody's house or whether it's in an open field where we can all share the benefits of it". This was a commonly felt notion among most of the respondents. These discussions about providing food for the benefit of others are supported in studies of community or communal gardens and the enjoyment

derived from sharing food with others (Earle, 2011; Taima Moeke-Pickering et al., 2015). I suggest that by providing food for family members and others, the gardeners were also contributing increased personal, collective and cultural capacities. As demonstrated in Chapter 2, the combination of environmental and social factors (gardening and sharing) can contribute to positive health behaviours, and increased wellbeing (Bandura, 2000b). These wellbeing experiences within their everyday urban living environments were a key motivation to tend the marae community gardens for many of the respondents.

In Chapter 5, I showed that the rapid urban migration of Māori since the Second World War generated a significant change from customary and collective to western and individualistic approaches to life and work (R. S. Hill, 2012, 2016). While everyday urban life places emphasis on personal achievement and individual mastery, marae gardens thrive from collective achievements and group accomplishments. Among the respondents, working with their fellow gardeners to tend and harvest food not only re-established links to collectivist benefits, but they also provided outcomes of productivity within their highly individualised living environment of cities. As discussed in my preceding chapter, this everyday activity of gardening is largely reliant on the respondents existing skills to produce tangible outcomes and actively worked to complete the associated tasks. Marae garden engagement increased the wellbeing of gardeners with therapeutic experiences linked to enjoyment, satisfaction and pride in their accomplishments. Since gardening is primarily based on existing and developing skills among gardeners, their involvement in the gardens provided important opportunities to increase feelings of self-worth and feeling productive in their urban lifestyles. As one student gardener (Interview, Student Group, Manurewa Marae, 24 October 2012) summed the discussions of many of the gardeners when he spoke of being proud of his garden achievement and his children's involvement:

> … so, you're proud of yourself when you can feed your family and you know it came out of the ground, you're proud of yourself when your kids are in there working with you and then you can see the joy in their face when they're … when their little plant is fruiting and then they eat it … they look at you and say "Can I eat it?" … "It's yours." "Can I grow some more?" … It's really exciting aye.

Similarly, for the homeless male gardeners, their time spent working the marae gardens provided many benefits in conjunction with affirming their ability to grow food. At a collective level, they all participated in providing food for others that kept them busy and feeling good from their contributions. One gardener (Interview, Homeless Men's Group, Ōrākei Marae, 24 May 2012) addressed this point; "I do it 'cause I like it, no matter how long it takes …". As Flach's (2010) argues that community gardens for homeless peoples has an important role for the homeless because it provides a space for them to prove their worth in a city that often fails or overlooks them. The garden was treated as a job by the homeless group and had a purpose that kept them active and returning. Hence, among all the respondents these feelings of accomplishment and being proud contribute both to cultural capacity and psychological wellbeing (Lainer et al., 2015; Okvat & Zautra, 2011; Poulsen et al., 2014).

Encouraging young people to work in the gardens and by doing so instil a sense of purpose and meaning was emphasised by several gardeners. In Chapter 4, I showed that the Tu'wusht Garden project in east Vancouver, Canada, operated their gardens with the purpose of encouraging urban aboriginal youth to work alongside elders and learn gardening (UBC Farms, 2014). The mission of the gardening programme was to provide support and opportunities to empower the capacity of youth with confidence and knowledge, which also contribute to employable skills. Several respondents spoke of a similar purpose for their gardens. As Brian (Interview, Group 2, Ruapotaka Marae, 3 August 2012) suggested that unemployed youth should get involved with his garden to gain self and group confidence, "Oh we'll show them how to do something more useful with their life". Delwyn (Interview, Delwyn, Makaurau Marae, 3 August 2012) argued that elders of her marae wanted to encourage younger marae members to get involved in their gardens and increase their confidence and capacity by acquiring knowledge and feeding their families:

> … they wanted to garden and they were enthused about passing on their knowledge about when they were younger and how productive it was out here in terms of life. Every whānau had a garden, fruit trees … just remember they didn't have to go anywhere to eat cause it was all here … and over the years they've noticed that obviously nobody's really doing that anymore and because they're older and they can't get out there and dig - they were quite enthused

Other gardeners concurred that having something productive to do within the social and cultural environment of the marae would benefit all of those involved, young and old. Tracey (Interview, Tracey, Makaurau marae, 15 May 2012) wanted to draw from the collective skills among her marae gardeners to provide gardening programmes for youth, she spoke with enthusiasm to provide these courses: "I would love to have run those types of things here…like level one for the kids oh you know even adults that are sitting around at home over here. You know at least they're doing something instead of sitting at home". At the time of this study, two marae were providing horticulture programmes for youth, Manurewa Marae had partnered with a local tertiary organisation to offer horticultural qualifications for their gardeners (see further Chapter 9).

Overall, the respondents were enthused that their produce and skills were being utilised and shared for the benefit of other family and marae members. The importance of these shared experiences and achievements contributing to self- and group connectedness and wellbeing has been identified as an important health benefit in numerous studies (Northrop et al., 2013; Walter, 2012). While this study finding adds to a wealth of current literature of the health benefits of sharing and caring experiences within community gardens, there is a small yet signification implication for urban Māori wellbeing. The marae community gardens provided the respondents with a means to experience shared purpose and accomplishment among family members in contrast within their more individualised hectic urban lifestyles. For a number of respondents it was apparent that this was one of the biggest personal motivating factors for marae garden engagement. This important finding highlights the important role of urban marae, as an urban-indigenous wellbeing site and health provider for Māori, not just for the structured health programmes with high level outcomes. More importantly, urban marae and the

everyday activity of gardens can produce and support simplistic but important outcomes of increased self- and collective emotional health and confidence. In my next chapter, I further expand on the integral and multi-functional role of urban marae for Māori wellbeing and the development of cultural capacity.

8.4 Conclusion

Figure 15: Nga Whare Waatea Marae 1

Photo 1 – The māra kai of Nga Whare Waatea Marae
Photo 2 – Discussing the progress of the gardens with Marae Manager Eddie Te Amo

In this chapter, I have demonstrated that the social experiences of family connectedness, altruism and productivity within marae community gardens are essential preconditions for indigenous wellbeing. This is primarily based on the consistent opinions of the respondents that socialising and sharing among fellow Māori was both a leading influence and outcome of their gardening on marae. In fact, contrary to my preconceived hypothesis that cultural experiences and consequential cultural development would be the foremost feature of marae gardens, the respondents' overwhelmingly prioritised social features. I showed that the wellbeing of urban Māori affected by aspects of social isolation and reduced intergenerational interactions compelled many of the respondents to engage in marae gardens. These concerns underpinned the efforts of the gardeners to mobilise on the gardens to strengthen their kinship ties and actively contribute to the collective wellbeing of urban Māori. By connecting and sharing among family within a Māori cultural context the gardeners were actively enhancing their sociocultural connectedness, knowledge and wellbeing. The gardens functioned as an informal social medium and cultural interface to connect family (tribal) members while sharing knowledge and produce. Gardening was a particularly meaningful experience because it anchored them to their family and past memories of their upbringing. Of particular interest to my study, was the emergence of discussions that emphasised the informal role of marae gardens as a useful interface for urban Māori to gain confidence and knowledge of their cultural ability in an everyday relaxing activity and space. Nonetheless, with a focus on socialising rather than a health activity the respondents acknowledged they principally attended the gardens to be in the company of fellow Māori.

While I had anticipated that the gardeners would attribute an increase in cultural wellbeing derived from the cultural environment of marae, none of the respondents spoke on this matter. This did not denote a lack of importance of the culture-centred environment of marae or associated experiences

among the respondents, but a result of my broad research question. Consequently, throughout my analysis there are few instances where participants delve deeper and *directly* into the cultural attributes of gardening. This would have been particularly useful given my inquiry into cultural efficacy. Nonetheless, there were numerous *indirect* narratives about the role of gardening in cultural maintenance. Marae garden participation generated connectedness amongst participants through collective processes and action and was supported by their existing skills and knowledge. This empowered many of the respondents through their contributions and productivity for their families and marae community needs. Although simplistic, the implications of these findings for future indigenous health initiatives is the need to ensure that urban indigenous people have the opportunity to easily socialise, share and give among their fellow members on culturally-loaded places. These are essential preconditions for indigenous cultural capacity and wellbeing, and the significance of marae garden engagement is that it provides an important example of how Māori can mobilise and address local issues and concerns. In the next chapter I substantiate and culminated my central argument that urban marae are a crucial component for the development of cultural efficacy and wellbeing.

Figure 16: Te Puea Marae gardens 2

Photo 1 – Small garden plots
Photo 2 – Overview of Te Puea māra kai

Chapter 9 Urban marae gardens: a multifaceted support for Māori wellbeing

Figure 17: Mataatua Marae 2

Photo 1 – Reviewing the māra kai of Mataatua marae with Whaea Rangitahi (2011)
Photo 2 – Restored māra kai (2012)

9.1 Introduction

In my preceding discussion chapters, I have demonstrated that marae community gardens encompass wide-ranging holistic experiences that significantly enhance Māori wellbeing. Marae gardening includes the more commonly known benefits for physical and social wellbeing, alongside unique experiences of enhancing Māori autonomy and developing cultural capacity (Houkamau & Sibley, 2011). Following on from this, I demonstrate the specific features of urban marae that lend support to the effective delivery of community gardens and holistic outcomes for family wellbeing. The physical venue of marae offers opportunities for tribal connections, cultural learning, alongside the therapeutic experiences of gardening. More importantly, urban marae can be viewed as producers and products of Māori empowerment. Yet, I show that urban marae face many challenges in remaining a central support of Māori health and wellbeing. The reality is that marae and community gardens have ongoing issues that affect Māori participation and therefore future sustainability (Tapsell, 2014). While many years ago marae were the focal point of Māori communities (R. Walker, 1992), this is no longer the current situation, as the marae of this study demonstrate. Nonetheless, marae have proven to be adaptable to meet the wellbeing needs of Māori in the face of many challenging circumstances such as neoliberal and urban forces. Throughout this chapter, I review the role of urban marae as a comprehensive and unique support for the holistic wellbeing of Māori.

In Section 9.2, I demonstrate that marae are sociocultural places that support the effective delivery of community gardens and the wellbeing of Māori stakeholders. Marae provide a space of care and support for Māori families to take part in cultural-collective activities that are of mutual benefits. Yet, while marae and the gardens are recognised as having an important role in connecting families and prioritising culture-collective health outcomes, there remain ongoing issues of Māori participation and marae underutilisation. Hence, community gardens were viewed as a means of advancing the return of Māori back to marae. Then in Section 9.2.1, I show that marae are regarded as urban refuges' for Māori, separated from their busy urban lifestyles. Within the both the garden and marae are opportunities for empowerment of Māori autonomy and development of cultural capacity, yet this may

be at a cost to personal autonomy. In Section 9.3, I further demonstrate the exercise of empowerment with the autonomous setting of marae for urban Māori. Currently, urban marae are being utilised as health delivery sites or Māori health providers. As marae provide health programmes for Māori and wider community members, they are providing Whānau Ora services, irrespective of governmental funding. Last in Section 9.4, I review the everyday features of marae that can be aligned to urban-indigenous therapeutic landscapes. Marae were considered to be homelike, open and accessible places for Māori to meet and engage in holistic wellbeing experiences. In Section 9.4.2, I show that marae community gardens provide important land-based opportunities and experiences for urban Māori including tribal (re)connections, physically and socially. Yet, within urban centres are issues of land limitations and quality that have affected the full utility of marae in meeting the needs of Māori. At the end of this final chapter, I provide a concluding argument highlighting the multifunctional contributions of urban marae, not only for the effective delivery of cultural-collective programmes and outcomes, but also the development of Māori autonomy and cultural capacity.

9.2 A sociocultural place

In Chapter 2, I argued that both self- and collective efficacy theories have limited understandings regarding the influence of environmental factors for indigenous peoples' wellbeing. Many behaviourist approaches underestimate the extent that environmental influences impact indigenous communities, and that health changes may not be feasible within social environments that fundamentally resist these changes. I demonstrated that cultural efficacy theory is more applicable because this framework recognises that environmental factors can enhance and impede the development of indigenous health behaviours (Houkamau & Sibley, 2011). For example, marae can provide important social and cultural experiences conducive for Māori wellbeing (Gillies & Barnett, 2012), yet social structural factors create substantial barriers for behavioural change (I. Anderson et al., 2016). Broadly, these barriers are the result of economic, social and political systems, that contribute to Māori experiences of oppression, racism, bigotry, and poor living conditions (Paradies, 2016). While social structural barriers remain an ongoing issue for Māori, I maintain that the effective utility of marae can provide a means of resolving or countering many of these issues. As I demonstrate below, this is because marae operate as multifunctional environmental support for Māori wellbeing. For example, marae are places of refuge, cultural-collective empowerment, land-based interactions, and health service delivery. Yet, although these are enduring features of marae, there are many contextual challenges in practice that affect Māori engagement. Nevertheless, the continued presence of urban marae signify the collective determination and interests of local Māori to provide a communal place that supports Maoritanga and family wellbeing (George, 2010). Hence, utilising urban marae as a setting for community gardens facilitates access to local environmental features and experiences that can influence positive wellbeing changes among Māori stakeholders. Throughout the following sections, I further discuss these main environmental factors including current challenges of community gardens within urban marae for Māori.

As demonstrated in Chapter 5, marae remain an integral representation of Māori culture and a tangible place for Māori to access a multitude of social and cultural experiences. Marae can be described as a 'locale of being' for Māori, because they provide a focal point for Māori to gather and partake in a wide range of culture-centred activities (Gillies & Barnett, 2012; R. Walker, 1992). As George (2012, p. 12) argues that marae have an increasingly important role "providing Māori with tangible and intangible links to traditions, values, spirituality, and other cultural practices – urban marae are able to provide the opportunity for those who wish it, to become part of a community of cultural relevance and significance". For urban Māori, living away from their traditional tribal areas, or those who have become disconnected from their tribal marae, urban marae provide a place of reconnection and opportunities for multifaceted sociocultural experiences (Tapsell, 2002) (see further Section 9.4.1). Māori academics have shown that marae can act as a cultural facilitator by providing role models, including peers and experts, within a supportive culture-centred context (George, 2010; Jansen & Jansen, 2013). These opportunities to establish or reinvigorate cultural connections and knowledge within urban contexts can be significant for reinforcing cultural identity while at the same time building cultural capacity (George, 2010; Wendt & Gone, 2012a). By locating community gardens within marae, Māori can access many of the sociocultural foundations available within, while engaging in an ordinary and everyday health exercise.

First, I provide a brief background of the respondents' marae engagement based on my interviews and observations. All of the respondents discussed a variety aspects of the marae in which their community garden was located. While some only made brief and generalised comments, over half of the respondent group spoke at length about the features and activities of their marae. With the exception of one gardener who only attended the community garden, all of the remaining respondents took part in other marae activities. These activities varied among the respondents from attending other programmes, supporting cultural events, or helping in the kitchen. Though for a small number of the respondents, the gardens were their main marae engagement rather than any other activities. Several of the respondents were active committee members and the community garden was only one of many other marae-based commitments. Generally, across the respondent group was familiarity with many of the activities taking place within their marae, as they discussed their varying contributions. In this regard, all the respondents had personal experiences and knowledge of the workings of their marae beyond the community gardens. Interestingly, several respondents had no tribal connections to the marae of their gardens, but spoke of their enjoyment of the cultural and collective features of gardening that influenced their participation (see further Section 9.4.1). The regularity of marae visits to undertake gardening ranged among the respondents between daily, to a couple of days per week or weekend engagement. A group of six respondents had initially only participated in the community gardens, and then became more actively involved in other marae activities. One of respondents' over a short period of time increased his marae involvement from gardener, to marae committee member and now full-time garden manager. While a small number of the respondents indicated that the gardens were their primary or sole interest, the majority agreed that their commitment was first to their marae regardless of the status of the community gardens. As demonstrated in my preceding chapters, all the respondents emphasised the social aspects of gardening influenced their continued engagements, and the knowledge that their efforts were of benefit to others.

During our interviews many of the respondents maintained that urban living has accentuated the role marae as a connecting place for families. These respondents further noted that the sociocultural experiences that transpired within marae and the gardens were not readily available within their homes or other communal places. Altogether, the respondents expressed understandings that the function or purpose of marae was for cultural-collective benefits rather than personal (Tapsell, 2002). In this regard, marae were places of care and support for families, as one respondent (Interview, Group, Nga Whare Waatea marae, 21 June 2013) succinctly argued: "when you come here, this is where we all nurture one another". The utility of urban marae as a place or 'space of care' has been highlighted in recent studies as a counter to the dislocation and disruption of Māori as a result of colonisation through the enactment of the cultural value of manaakitanga (P. King et al., 2015). Hence, many respondents wanted to encourage more Māori families to embrace their local marae and community gardens to share in mutually beneficial experiences alongside strengthening sociocultural connectedness. These respondents reflected that increased local community involvement in their marae was of reciprocal benefit, and the future sustainability of marae was dependent on community engagement. As one respondent (Interview, Anon. 1, Makaurau Marae, 27 June 2012) maintained that social activity kept the marae 'warm', as currently experienced by elder marae members:

> … because I know the nannies were coming down and just pottering around in the garden and you know it was a nice time for them just to be together and to chat and to talk and to catch up and even if they didn't do much weeding they still had somewhere to go to do something and I think it's also great - it keeps our marae warm; that there's people that are coming not just for a tangi not just on a weekend for a wedding or a birthday, but that they're coming at all different times of the week to go to the nursery and potter around and do something.

This quotation highlights that marae provide not only a vital place for Māori cultural activities, but also casual social and physical activity across many ages (Gillies & Barnett, 2012). Other respondents' similarly identified the marae gardens as a place for social interactions and connections (refer Chapter 8). Interestingly, one respondent (Interview, Anon. 1, Makaurau Marae, 27 June 2012) joked that she made more effort to attend and socialise within her marae than in her local neighbourhood: "I hardly ever see my neighbours, but I make an effort to see my whānau". This comment further highlighted the influence of family for both marae and community garden engagement (George, 2010).

Much of the conversations with the respondents regarding their marae centred on social experiences, and that they had purposely tended the gardens to be among fellow Māori. Several gardeners viewed the marae community gardens as a means of bringing urban families together and sharing in wellbeing experiences, as Wyn (Interview, Wyn, Nga Whare Waatea Marae, 21 June 2013) explains:

> … the garden … will help model to whānau saying "Look, we're gonna come and we're gonna prepare the food, or kai, so we can eat together … and we're gonna harvest the food from our garden". So to be able to model that, is really important I

> think, because that that will trigger or germinate perhaps those urges and aspiration to do that with [their] whānau … So I think if it achieves that … that's incredibly powerful

Increasing Māori participation and support of marae was a shared goal among many of the respondents. As mentioned in Chapter 7, all of the study marae experienced ongoing issues of low Māori participation within all levels of operation. Yet, studies reveal that this is not an issue specific for urban marae, as rural marae also face challenges of sustained Māori participation and commitment (Tapsell, 2014; Te Puni Kōkiri, 2012d). As discussed elsewhere, the lack of Māori involvement with marae can attributed to the ongoing consequences of the processes of colonisation and urbanisation, and the resulting undermining of cultural foundations (Axelsson et al., 2016; Kirmayer & Brass, 2016). Nonetheless, some respondents expressed their optimism that their community gardens would inspire family and community members to engage not only garden, but also join the other activities of the marae. For example, Tracey (Interview, Tracey, Makaurau Marae, 15 May 2012) commented: "first and foremost for them to get involved with the marae if not that way, then yeah through the gardening and then maybe they'll get excited about coming to the marae meetings and maybe they would get involved in other things". Four respondents argued that the importance of increased Māori participation was directly linked to the future sustainability of marae. As noted by one respondent (Interview, Anon. 2, Makaurau, 18 July 2012) that "what people don't realise is without people our marae is just land with buildings on it". This brief statement underpins both the traditional and now increasingly contemporary social purpose of marae. Attracting new community gardeners and marae members was discussed as an ongoing challenge by many of the respondents.

Several respondents recalled childhood memories of marae as a social hub or focal point for their tribal community, yet these memories also served as reminders that marae were no longer utilised regularly by local Māori. As Lionel (Interview, Lionel, Papatūānuku Kōkiri marae, 24 May 2012) reflected: "The marae was like the heart of the community; the life-line of the hapū". While marae still function as a culture-centred hub for Māori communities, a large number of the respondents were aware of effects of low participation. In this regard, these respondents maintained that marae were losing their value in the everyday of lives of Māori. These arguments of the respondents concur with the findings of George's (2010) study that emphasised that marae have increasingly become just a place to visit rather than stay. One gardener expressed concern for the future viability of her marae if it 'sat idle' for too long. Another respondent maintained that the wellbeing benefits of both marae and land-based experiences were overlooked by wider family and community members. Ngahuia (Interview, Ngahuia, Ōrākei marae, 16 May 2012) argued that "our whānau take our whenua for granted, it's right at their doorstep and they don't really know ... appreciate what they got, we're from the generation where we knew when we lost it, and then we got it back you know". This respondent had tribal experience of land confiscation and the struggle to reclaim and retain their land and marae in the city (see Chapter 5). At the time of this study, she was the current nursery manager of her marae and had first-hand knowledge of long-term lack of participation by marae members in both the gardens and nursery.

Another respondent (Interview, Anon. 2, Makaurau Marae, 18 July 2012) further highlighted the wide spread concern of the respondents and the current underutilisation of their marae:

> …the marae has become … it has become obsolete in peoples' lives which sounds awful but … that's probably the truth of it, where it was the heart beat to our existence, it's now … it's a place for tangi, it's a place for everything else except a place where you can use it to" and "it's just a place I suppose, it's sad but it's … but yeah, that's our reality I suppose, so we've lost sense of it

These discussions of the weakening of Māori from their cultural foundations are echoed within current literature reviewing the current and future role of marae (George, 2010; Gillies & Barnett, 2012; Tapsell, 2014). One respondent (Interview, Group, Nga Whare Waatea Marae, 21 June 2013) made a short statement which captured a general consensus of opinion among the respondents of the past and present role of marae: "Our marae taught us how to survive, taught us how to survive on what we had". Many of the respondents felt community gardens or similar health activities were an important vehicle for reconnecting Māori back to their marae and Māoritanga (Gillies & Barnett, 2012). More importantly, marae provided important life experiences of mutually beneficial support and caring for all family members. Speculation among the respondents of the reasons or causes of low Māori engagement were wide ranging as highlighted in Chapter 7.

Of note, as the respondents discussed at length the social features of the marae environment as experienced through community gardens, very few commented on the cultural features. As discussed elsewhere, I did not specifically query cultural aspects of the marae or the gardens, and consequently this topic was seldom mentioned. I speculate that 'unprompted' discussions may have been lacking as the marae was considered an ordinary culture-centred environment, and any qualities or cultural learning experiences were a natural occurrence and therefore not explicitly mentioned. This research oversight has resulted in gap of knowledge regarding the environmental contributions of the physical features of marae (wharenui and wharekai), and influence of these specific marae-based factors for increased urban Māori cultural identity development. Numerous studies have demonstrated that culture-centred environments provide vital learning opportunities to support the construction and maintenance of a cultural identity (Adds et al., 2011; Becker et al., 2012; Walters et al., 2011). Yet, the role of marae for enhancing Māori identity was not specifically mentioned by the respondents. Despite this lack of discussion of cultural factors, as I further discuss in upcoming sections, the respondents alluded to their comfort in being within the culture-centred environment marae, which increased their sense of belonging to Māori and local community. Importantly, several respondents suggested that marae provided an alternative place that supported 'being Māori' compared to their everyday urban living conditions. As one respondent (Interview, Anon. 1, Makaurau Marae, 27 June 2012) aptly described the contrasting environments: "for the marae it's kinda like, a little bit different and I think maybe it's because you're doing things with [and for] your whānau". As I show below, this notion of marae as a separated place that reinforced a cultural-collective ethos was shared among many of the respondents. Further to this, the discussions of the respondents also revealed that marae supported experiences of empowerment of Māori autonomy.

9.2.1 An urban refuge for Māori

Marae present a Māori-centred place away from dominant colonial lifestyles and ideologies (M. Durie, 2006; George, 2010; Gillies & Barnett, 2012) (see Chapter 5). They are places of Māori control and cultural-collective characteristics, separate from the more individualised lifestyles of external urban environments (Bennett, 2007; Tapsell, 2002). Hence, many of the respondents identified their marae and gardens as a separated safe haven within their everyday urban living circumstances. This shared notion of a 'refuge' noted by the respondents' aligns urban marae to the function of urban-indigenous therapeutic landscapes (Wendt & Gone, 2012a) (see Chapter 3). As I will further show, a small number of respondents also identified collective experiences of empowerment within their gardens and the wider marae environment. In Chapter 5, I demonstrated that marae are unique environments for Māori, because they can offer collective experiences of empowerment in decision-making, shared leadership and achieving mutually determined goals. Marae have continued to remained one of the few places in which Māori have collective control and authority in the daily operation and activities (Bennett, 2007; Tapsell, 2002). Māori autonomy is maintained within each marae, as affiliated members determine the use or operation of marae as mandated by their family and wider marae members (Gillies & Barnett, 2012). While marae are not immune to governmental policy and neoliberal influences, the primarily utility of marae remains with the control of the marae community and committee members. In this regard, marae as the host for community gardens provides urban Māori with a place of refuge within their city environments, and also unique empowering opportunities to exercise autonomy. Yet, as the respondents showed collective autonomy within marae can be both rewarding and challenging in practice.

Interestingly, one of the main contributors to the discussions of marae gardens as separated or Māori-centred place opposed to urban living was one of the homeless male gardeners. During our interview Colin (Interview, Homeless Men's Group, Ōrākei Marae, 24 May 2012) did not disclose his circumstances of living on city central streets, yet he was very clear about the value of the marae and gardens for his wellbeing:

> This is like paradise …and I just like being here it's like being in heaven, better than that concrete jungle over there 'cause I live in that concrete jungle every day and I have to put up with everyone's crap, when I'm out here I feel free, feel at home.

While Ōrākei was Colin's tribal marae, he was homeless and working on the gardens offered him respite from the hardships of living on the streets (P. King et al., 2015). Colin emphasised that for him, the garden provided a relaxing place to meet with other 'streeties' and enjoy the atmosphere and scenery. He explained further:

> I just want to be here because I've 'streeted' it out here before and I loved it, loved the beach and love the people that live around here we've had some bad things that have

> happened in this hood - love thy neighbour, love thy enemy no matter what. Oh I love it here, it's just awesome, I'd love to have my children stay here part as this marae.

Other respondents pointed out that there were both physical and meta-physical differences between their marae and wider residential areas (M. Kawharu, 2010; R. Walker, 1992). For example, Lionel (Interview, Lionel, Papatūānuku Kōkiri Marae, 24 May 2012) maintained that "when you go out that fence … get out of that gate it's a whole new world". He further indicated that one of the main differences was the less hectic and relaxed atmosphere of his marae gardens. Two other respondents maintained that they found marae relaxing because they had the freedom to work the garden at their own pace, in contrast to their daily experiences at work. As described by Wyn (Interview, Wyn, Nga Whare Waatea Marae, 21 June 2013), "let's not just be distracted by the demands of modern day living and the demands of our job, let's not forget some of the richer more enjoyable components of living". For many of the respondents, the marae and community gardens were comforting and calming places, in which they were surrounded by fellow Māori. Several respondents noted that setting their own pace to work in the gardens, and partaking in learning experiences or socialising with other family members were features they enjoyed. Wyn (Interview, Wyn, Nga Whare Waatea Marae, 21 June 2013) explained further the casual nature of the marae gardens enable a mutually beneficial exchange between gardeners and the marae:

> … this is a marae, it's shared, it's ours, and there's an opportunity to perhaps pay back what a marae gives you through a little bit of simple 'mahi'. It's easy to do, easy to plug in, easy to schedule, no big dramas about it, turn up and do it by yourself for half an hour if you wanted and then just acknowledge I guess your marae, so you see that as a great aspect as well.

Notably, as I have argued elsewhere, the simple health approach of community gardening, as opposed to the more structured and measured approach of many external health programmes, was universally viewed as an important influence for the respondents continued engagement.

Aside from the discussions of marae as a safe haven, a small number of respondents also discussed features of empowerment within their garden and marae environment. These respondents spoke of their contributions to the planning, commencement and maintenance of their gardens. At the time of this study, six respondents were the managers of their marae gardens, and of this number two respondents tend their gardens primarily alone. All of the respondents selected their produce for their garden plots, yet the committee had overall control of the size of each garden. Fifteen of the respondents highlighted varying experiences of attending their marae committee meetings, as members and casual observers. One respondent spoke at length of recent experiences of increasing the productivity of the community gardens and approaching the marae committee with a proposal. This respondent noted that the decision-making was a mutual process with the committee as considerations were made for the best interests of the marae and community. As explained further by a respondent (Interview, Anon. 2, Makaurau Marae, 18 July 2012), "for our trustees it was about how can we commercialize the nursery we wanted … we wanted it to be two-fold where it was not only

commercially viable but it was also sustaining our families around home". These joint decision making processes were important for this respondent, and the empowerment of autonomy. Interestingly, as the respondents spoke of their gardens and features of empowerment, none of the respondents identified associated leadership factors. While local leadership within community gardens has been highlighted in studies as a central feature or outcome of engagement (Alaimo et al., 2016), this characteristic was not discussed among the respondents. One group of respondents from the same marae identified and spoke highly of a founding marae member, yet for the most part none of the respondents' spoke of garden leadership. I suggest this occurred because the majority of my respondents were leaders in their gardens, but did not self-identify as such.

Notably, due to the collective marae autonomy of the garden plots, some respondents noted that their personal autonomy was sometimes overruled by marae committee decisions. This conflict of personal autonomy and collective autonomy has been highlighted in health studies as a challenge for health behaviour change within indigenous communities (Eckhardt et al., 2014). Despite this, Ngahuia (Interview, Ngahuia, Ōrākei Marae, 16 May 2012) countered that this was an expected occurrence within the collective workings of marae: "when you have an idea, you can't just say, "We are going to do this" you got to take it to marae committee. You have always got to take it to marae". Another respondent (Interview, Group, Nga Whare Waatea Marae, 21 June 2013) argued that collective empowerment and autonomy contributed to the commencement of their gardens:

> … we as a team had this vision from the beginning to the end, and we have an outcome … a bit like the recipe … the method, the ingredients, the outcome kinda thing, so I've kept a running history of every interaction, every moment I've walked in to the area of māra kai so that it shows the history the whole way through

This respondent enjoyed the collective experiences and outcomes of working with the marae committee which she further commented created an important model for future marae health projects. Overall, the respondents viewed the decision-making processes of planning and running of their gardens as fundamental for sustainability.

This section has demonstrated that marae were generally viewed as a sociocultural supports for Māori wellbeing. While there remain challenges in Māori participation for both the marae and gardens, the respondents clearly identified the marae as a supportive environmental influence for personal and family health and wellbeing. As discussed elsewhere, supportive wellbeing environments include both physical and social factors that can protect against ill-health, and also enable people to increase their capabilities and develop autonomy with regard to their health (Bloch et al., 2014). Next, I focus on the respondents' discussions that identified marae as a vital health delivery site for improved family wellbeing.

9.3 A health delivery site for whānau ora

Health researchers argue that addressing indigenous health issues requires more than acknowledging different sociocultural contexts and incorporating cultural-collective approaches into programmes; it is also about empowering indigenous peoples' health autonomy (N. S. Berry et al., 2014; Hamerton et al., 2014; Laliberté et al., 2009). Health academics concur that empowerment within indigenous communities contributes significantly to increased cultural-collective capacities and the ability to identify and solve health issues according to their own priorities (Demaio et al., 2012; Mittelmark, 2014). Hence, health strategies can be more effective when based on understandings of local context and history to ensure that programmes can address local issues (Richmond & Cook, 2016). Health academics maintain that 'rooting' interventions in the social context of specific settings can help address local issues, by taking into account social structures such as race, diversity and cultural-collective behaviours (Alegria et al., 2010; Shareck et al., 2013). Programmes can then be adapted and optimised to reflect specific contextual contingencies, and enable the community settings to be utilised as health promoting (Kokko et al., 2014; Poland & Dooris, 2010). In Chapter 3, I argued that sociocultural places within indigenous communities can be utilised to facilitate effective and appropriate health programmes. This entails a 'settings' approach to health strategies which has important implications of empowerment for indigenous peoples health autonomy (Bloch et al., 2014; Dooris, 2009). Within indigenous communities, applying a settings approach contributes the empowerment of community members as they collectively create and control their own health programmes based on local knowledge of sociocultural context and achievable collective outcomes.

Locally designed programmes can also incorporate knowledge of cultural history, values, and behaviours to guide the most effective health approach for the community (Gone, 2011a; Sabone, 2009). Indigenous community members also have first-hand knowledge of the limitations and constraints of their communities, including the social determinants that affect their everyday lives and the feasibility of wellbeing programmes (A. Boulton et al., 2011; Demaio et al., 2012). The complexity of indigenous health issues is significant due to ongoing socioeconomic circumstances and structural issues (Mitrou et al., 2014; Newman et al., 2015) (see further Chapter 3). Hence, expectations of health change can be unachievable without understandings of the influence of dominant non-indigenous cultures and its oppression of indigenous peoples (Kirmayer & Brass, 2016). By placing health programmes within the everyday settings and control of Māori communities contributes to the relevance and outreach of health strategies. Importantly, Maori community-led health programmes are empowering as members are directly involved in making decisions about their family and community wellbeing (see Chapter 3). Notably, health strategies can also encounter difficulties in application within indigenous communities when they are viewed as imposed by 'outsiders' and non-responsive to local community needs. For indigenous peoples who have a distrust of western health systems and services, alternative healthcare places such as marae can be more responsive and culturally relevant for their health and wellbeing requirements (S. C. Thompson et al., 2015; Walsh, 2014). As demonstrated in Chapter 3, localised health programmes and services are empowering for stakeholders' autonomy and cultural capacity as they develop wellbeing strategies linked to the recognition or advancement of their cultural foundations, while focusing on equity of health outcomes.

As I briefly discuss the utility of marae as an effective health site or health provider for urban Māori, I acknowledge that this topic was not widely reviewed among the respondents. While the respondents were aware of the rise in health services and programmes based within urban marae (A. Boulton et al., 2013; Ngati Whatua Orakei, 2014), there was little discussion on this matter during our interviews due to the focus on community gardens. Nonetheless, I maintain largely based on observations and casual conversations that as site for health promotion, each marae have many attributes that enabled them to provide effective and locally responsive activities (Gillies & Barnett, 2012). Studies have demonstrated that marae can draw upon a broad range of localised resources, social and cultural, that can fulfil not only primary health outcomes but also secondary outcomes such as improved cultural connectedness, confidence and ability (R. Brown, 2010; Hamerton et al., 2014). This notion was supported by one gardener (Interview, Group 1, Ruapotaka marae, 27 June 2012) who expressed the rationale for her continued involvement with her marae was a reciprocal relationship of community involvement and strengthening. She added her marae was providing wellbeing programmes that involved her community members as programme deliverers and participants:

> Just being involved with the people … just seeing some of the programmes that they're putting through the marae … seeing how they're involved with the community and really just that, having that hands on experience with people and the marae, with such a friendly setting it's cool.

Other respondents also noted the importance of local programs that cater for the needs of their community (Barnett & Kendall, 2011; Mundel & Chapman, 2010). Community gardens were considered by the respondents as providing multiple health and wellbeing experiences for marae families and wider community members (refer Chapter 7 & 8). A majority of the study marae are situated within lower socioeconomic neighbourhoods where economic inequalities have resulted in poor health and wellbeing outcomes (J. Reid et al., 2013). Thus, the gardens provided not only experiences of empowerment for the respondents, but also a practical and local means of growing food. The reasons for setting up the gardens varied between each marae, including family plots, teaching gardens and tertiary gardens. Several respondents provided food for not only the marae, but also local food banks and other family members. At the time of this study, one garden provided young mothers with the tools to not only learn how to grow produce but also how to preserve and cook it for their babies.

Many respondents argued that one of main functions of marae was to host wellbeing activities, including health, youth justice and social programmes. These respondents indicated that the activities of marae were dictated by local context, including the immediate needs of marae whānau. At the time of this study, all of the marae had experiences of hosting government contracted health services, and many marae also independently provided health programmes from their own funds and resources. In this regard, each marae not only hosted community gardens, but also a wide range of other social services and health activities. These activities included; computer studies, diabetes groups, Tai Chi, Marae aerobics, ukulele classes, fitness and weight loss programmes, cooking lessons, nutritional

classes and boot camps. Alongside these more generalised wellbeing activities, all of the marae also provided Kapa haka, waiata and whaikorero classes. Many of these activities were designed and delivered by marae members, and a small number of respondents were involved in these programmes in varying capacities. A majority of the marae also hosted community service activities, including periodic detention. Interestingly, on one marae, several probation workers continued to work in the community gardens after their community service had ended. Altogether, each marae had autonomy over these marae-based programmes.

At the end of this section, I make the observation that not all of the marae were contracted to provide Whānau Ora programmes, yet many of their existing programmes aligned to the government philosophy and initiative Whānau Ora (Te Puni Kōkiri, 2012c). This occurrence within my case study marae, highlights the argument made by Dr Papaarangi Reid (Families Commission, 2011) that whānau ora is a Maori wellbeing service that marae have been delivering, largely without government assistance for many years (refer Chapter 5). Marae are long-term and existing whanau ora providers. As discussed in Chapter 7, marae require more governmental support in terms of funding for wellbeing activities, given the current Māori health circumstances then further considerations are required for alternative and more cultural-collective approaches. As I show next, marae can provide everyday therapeutic experiences for Māori wellbeing that can complement health programmes. While simplistic, these land-based experiences of tribal connectedness are essential supports for Māori family wellbeing.

9.4 An everyday urban-indigenous therapeutic landscape

Maori academics have demonstrated that urban marae are more than symbolic places for Māori, they also offer opportunities for connection or reconnection to spiritual relationships with land (Tapsell, 2002; Toi, 2014; R. Walker, 1975). In this regard, marae are therapeutic landscapes due to their function as a vital support for Māori by providing a location for social networking, alongside facilitating land relationships and therapeutic activities (P. King et al., 2015; A. M. Williams, 2010). As demonstrated in my preceding chapters, marae encompass multiple health benefits and experiences, including physical and emotional health benefits, alongside relational, symbolic, spiritual and healing benefits. Therapeutic landscapes studies have identified that places that are considered ‘everyday’ can provide health and healing experiences for indigenous peoples (English, Wilson, & Keller-Olaman, 2008; K. Wilson, 2003). In this section, I further maintain my argument that marae are everyday urban-indigenous landscapes that enable multiple wellbeing experiences for Maori including facilitating both land-based and tribal (re)connections. Notably, urban marae are therapeutic places of holistic wellbeing both physically and spirituality (Gillies & Barnett, 2012).

In Chapter 3, I showed that the ongoing dislocation and disconnect for indigenous peoples from their tribal land as a result of colonial policies has had a marked effect on indigenous wellbeing. As Kingsley (2013, p. 683) argues, “disconnection from land can compromise cultural connections which can cause extreme distress and powerlessness, commonly felt by many indigenous groups

worldwide". This statement resonates within indigenous wellbeing studies that demonstrate the important relationship between indigenous people, land and wellbeing (Biddle & Swee, 2012; J K. Tobias & Richmond, 2014). These studies have shown that indigenous relationships with land includes making physical and spiritual connections, or revitalising connections, which is an important process for mental health, treatment, wellbeing, and healing for indigenous people. Similar to these issues for indigenous peoples globally, Māori wellbeing has been severely impacted as a result of tribal land displacement, urban resettlement and land rights disputes (J. Reid et al., 2013). While ongoing contestation remain for Māori in terms of return of tribal land or relocating to new urban areas (refer Chapter 5), marae community gardens provide urban Maori with the opportunity to establish new land and tribal relationships. Community gardens can also be utilised as means for local Maori to reconnect to their tribal land and social relationships that may have weakened due to the processes of colonisation and urbanisation. Below, I review the respondents' discussions that focused on the environmental features of their marae and gardens in terms of a physical place of interactions and connections for their holistic wellbeing. For many of the respondents, the marae gardens provided a physical and tangible means to enter into a mutually beneficial relationship between working the land, providing for their families and connecting to place.

As the respondents discussed the physical characteristics or qualities of marae as a setting for community gardens, many of their descriptions aligned to the emerging concept of urban-indigenous therapeutic landscapes (Wendt & Gone, 2012a). One of the most common descriptions among the respondents was the homelike and familiar features of marae as a complementary setting for their community gardens. As Wendt and Gone (ibid.) highlighted in their study, the homelike features of therapeutic landscapes can be integral for urban indigenous peoples by enabling a feeling of comfort and safety while partaking in health activities. In consequence, six respondents directly referred to marae as their home or second home. For example, Kylie (Interview, Group, Nga Whare Waatea Marae, 21 June 2013) commented: "marae is a place you can come to … it's a home". Other respondents argued that marae were a home place for all Māori, not just those who were tribally affiliated. As one respondent (Interview, Group, Papatūānuku Kōkiri Marae, 27 July 2012) explained that her marae was homelike and open to the community: "this marae, it's been like a second home to us and a place of belonging and you don't have to be ashamed of sharing your ideas or your views or anything being judged. So I reckon, that every marae should be opened to the ... like opened like this". Notably, this respondent highlighted that marae should be considered open forums in which people should feel comfortable and safe to express their thoughts and concerns within this forum. This notion of utilising marae as a safe space for sharing emotions among fellow gardeners and family members further highlighted the alignment of urban marae to therapeutic landscapes (Perriam, 2015; A. M. Williams, 2009).

Combined with homelike qualities several respondents indicated that urban marae were open and accessible places. In this regard, two respondents argued that marae need to be utilised as communal centres and open to all community members, Māori and non-Māori. As Delwyn (Interview, Delwyn, Makaurau Marae, 3 August 2012) explained that a core role of marae is community-health focused and that "it [marae] should be a functional place that anybody can go to at any time". She further

elaborated that in consideration of low community participation for her marae, that it was an ongoing responsibility for all current marae stakeholders to inform wider family and community members that the marae was open for all. Other respondents commented that local community members may not be aware that marae were flexible sites that could host a wide range of activities for family and community groups. Another respondent (Interview, Group 1, Ruapotaka Marae, 27 June 2012) added that marae had a responsibility as a community focal point to keep families informed and connected. She felt her marae was achieving this goal: "I think our marae has been really good at that over the last couple of years, keeping people connected with what's going on, what's happening and bringing you back". This respondent acknowledged that keeping marae families connected with current programmes and activities was integral to their return and maintaining community engagement. As discussed in Chapter 7, keeping Maori informed and engaged with both the marae and community gardens was an ongoing issue.

When reviewing the site of the gardens within the marae, many of the respondents' identified wide ranging therapeutic experiences of working the land while engaging with other family and marae members (Milligan et al., 2004; Pitt, 2014). As discussed in my preceding chapter, intergenerational experiences within the community gardens were described as invaluable wellbeing experiences for many of the respondents. Several respondents were clear that marae enabled these intergenerational exchanges to take place (Gillies & Barnett, 2012). These respondents maintained that intergenerational experiences were not limited to gardens, but also could take place within many of the other activities of the marae. A common consensus among many of the respondents was young people were missing out on essential wellbeing experiences of being with their grandparents or elderly community members. In this regard, marae and the gardens served an important function in providing an open and accessible place for young and old people to socially connect. As Tracey (Interview, Tracey, Makaurau Marae, 15 May 2012) argued intergenerational exchanges need to be encouraged in urban centres because essential cultural interactions have reduced over the years and young people are missing out. She commented: "their generation have missed the boat where they've been taught by their grandparent's type thing…because I was in the generation that did get…you know all that knowledge and some of these ones haven't". Tracey and several respondents concurred that marae provide a place to access the knowledge and wisdom of elders for urban Māori and wider community members.

Interestingly, as mentioned in preceding discussion chapters, the marae gardens were viewed by a small number of respondents as an informal pathway for re-establishing marae and Māori values back into the everyday lives of Māori families. For example, Brian (Interview, Group 2, Ruapotaka marae, 3 August 2012) explained the more simplistic and collective benefits of marae gardens:

> … the garden project here…it's about bringing those values back into community, back into Marae, back into the people that belong to the Marae … even some of them when I walk past, I don't know them but I would like to say to them haere mai (come in), come and have a look round the back and even if I walk them though the back through the garden out of the way.

Brian further elaborated that the sociocultural benefits of gardens can help re-centre marae as a traditional and contemporary feature within urban Māori lifestyles:

> … we come back to the marae from being away in the city doing city stuff, we come back to the tūrangawaewae, Papatūānuku and…it's quite exciting where we are at, to where our goals are to encompass everybody on the marae; visitors, manuhiri, tangata whenua and getting everyone involved with the marae here. Marae gardens as a form of sustenance, as a form of going back to our culture of what was…going back 150 years ago kind of thing…and working with the different kai and…I would like to see as a vision, incorporating that into modern society today…to bring the past into the future…to meet up with the future

Following on from discussions of contemporary utility of urban marae, two gardeners stressed the importance of their gardens as a vehicle for providing a relaxed entry onto marae for urban Māori. One respondent argued that urban Māori now have a diverse range of marae knowledge and experiences, consequently the formalities of marae procedures can be discouraging to marae participation. This respondent commented that the gardens were a "non-threatening way" to enter the space of marae. As Wyn (Interview, Wyn, Nga Whare Waatea Marae, 21 June 2013) elaborated that new gardeners can take advantage of the garden as an informal entry onto marae:

> … they have an opportunity to actually involve themselves with an activity at the marae, say a pōwhiri (welcome ceremony) or something … so we [marae members] see an opportunity of breaking down that kind of distance, that geographical distance through these types of activities.

Aside from this brief comment from Wyn, the majority of the respondents did not identify barriers of entry for their involvement with their marae. While in Chapter 5, I highlighted debate regarding the 'accessible' and 'everyday' features of urban marae, these issues were not discussed among respondents. All the respondents had self-determined their regular engagement within the gardens or the marae and expressed no discomfort. Yet, as many of respondents have previously discussed, Māori participation is an ongoing issue, which I suggest can be linked to issues lack of cultural confidence and unfamiliarity of marae (George, 2010; Tapsell, 2014). The paradox is that marae gardens can contribute to enhanced cultural efficacy, yet increased cultural confidence is often required to influence marae engagement. Nevertheless, among the respondents, marae and community gardens offered important everyday therapeutic experiences. In the next section, I review the contribution of marae in providing opportunities for urban Māori to engage in land-based and tribal connections within their urban living environment.

9.4.1 A place for land and tribal connectedness

Experiences of working and maintaining gardens on tribal land can be empowering for cultural wellbeing through the establishment of a sense of [re]connection or belonging, to community and land (Milburn & Vail, 2010; S. L. Thompson et al., 2013; B. Turner, 2011). Belonging is linked to wellbeing because it is correlated with improved self-esteem and self-identity (Pearce & Pickard, 2013; Stuart & Jose, 2014), and can also provide powerful motivator for engagement in specific environments, activities and occupations (Gillies & Barnett, 2012; Hammell, 2014). Recent studies have demonstrated that increasingly urban indigenous peoples are purposively seeking out places in which they can connect with their culture, land and tribal group in an effort to obtain an enhanced sense of identity and connectedness (DeCou et al., 2013; J K Tobias, 2015). Yet, the process of belonging and connection between people, culture and place is complex. Researchers concur that it complex because it involves a multifaceted process involving social, cultural, emotional and spiritual engagement between people and place (Perriam, 2015). In New Zealand, marae provide a unique and comprehensive place for Māori to access many tribal sociocultural connections, knowledge, and skills (Tapsell, 2014; R. Walker, 1992).

As noted in Chapter 5, all of the marae of this study represented differing tribal representations including local, pan-tribal or out-of-area tribes (see further Tapsell, 2002). Similarly, the total respondent group comprised of a combined mix of local and out of area tribal affiliations. During our mihimihi and interviews, a majority of the respondents spoke of tribal connections to the marae of their gardens. Some acknowledged an affiliation to more than one marae, including their current urban marae and one or more elsewhere in New Zealand. Several respondents admitted that their garden engagement was primarily due to their tribal affiliations to the marae and their commitment to marae-based activities with other family members. A group of approximately eight respondents noted that they did not have any tribal links to the marae of their community gardens. This group mostly comprised of the student and homeless gardening groups. The opportunity to participate in community gardening was a leading influence for these respondents, regardless of tribal affiliations. Other respondents' indicated that working within their marae gardens provided an important time and place for them to reinforce both social and physical tribal affiliations.

Four respondents referred to their parents' or grandparents' previous involvement on their marae as the rationale for their commitment and attendance. One of these respondents added that because of her parents' affiliation and commitment that she was consistently helping the marae often regardless of the activity. As Tracey (Interview, Tracey, Makaurau Marae, 15 May 2012) demonstrated, it was a combination of passion and affiliation for the marae and her family which enticed her to participate in the gardens of her marae:

> I suppose it's passion … the main thing is that I'm from here, and knowing what my nannies and that did you know before - in their era to grow food…I just feel like there's nobody around at the moment doing that …trying to make our whānau be involved but probably the big thing, passion just love doing it you know, it's relaxing

Tracey's past and current family links to her marae alongside her passion for gardening was evident as a lead driver of her garden participation. Gardening as a healthy tribal activity among young and old, and as a means to reconnect generations was prevalent in many of her discussions.

Notably, some respondents maintained that there were some differences in the operation or function between urban and rural marae. This difference was specifically aimed at urban marae that were new and pan-tribal (see Chapter 5). These discussions regarding perceived urban differences resonate with current discourses, including debates of the validity of being urban Māori versus rural Māori (Kukutai, 2013). For example, one respondent (Interview, Group 1, Ruapotaka Marae, 27 June 2012) explained that often urban marae were not comprised of immediate family members, unlike her rural marae:

> Whereas on a rural marae you can go to whānau, and heaps of kids down then they'll be there, you gotta get this thing off the ground and go and see the elders and they'll go down and go tell the young ones, but over here in an urban marae it's a little bit different …and I can't associate my feelings really with an urban marae, if I'm talking about marae I could be to my marae setting and like I said the dynamics in my marae back home and the dynamics in an urban marae are a wee bit different although what do you call it? The protocols are pretty much the same but usually it's … they're vastly … two worlds apart, not two worlds apart but they're just different".

While this respondent identified key differences, she further added that this factor did not deter her participation. This was similar for all the respondents whom despite their non-tribal affiliations purposely chose to engage in the marae community gardens. One respondent was surprised that although urban marae were situated within largely populated areas, this did not result in increased attendance. As Wyn (Interview, Wyn, Nga Whare Waatea Marae, 21 June 2013) explained: "you must see it when you come down to the city, the difference between living in those small communities, the way we live in the city … there's more people but there's less people". This point made by Wyn serves to highlight the difficulties for marae survival within urban contexts. Due to diverse circumstances and understanding of Māori, while urban population have increased, urban marae engagement has not.

The challenges for traditional marae in urban centres due to relocation issues involving colonial processes was discussed at length by two respondents. In Chapter Five, I showed that Ōrākei tribal members have endured land confiscation, relocation of their marae and the loss of land. One of the elder gardeners (Interview, Grant & Nic, Ōrākei Marae, 10 October 2012) argued that the consequences of relocation for Māori have affected the tribal connections and relationships to land. He spoke of these consequences not only for his tribe but also their relationship with the land:

> .. Pākehā sort of … re-located us into areas where a lot of … things wouldn't grow. We didn't have enough basic lands we didn't have enough community marae's, when we came we became urbanised we were put out into Otara, without any relationships

> to the lands or the whakapapa or the waters or the mountains or whatever we had no relationships.

Accordingly, studies have demonstrated that colonial policies of land dispossession and relocation has had significant consequences for Māori identity formation, cultural knowledge and wellbeing (R. S. Hill, 2016; M. Kawharu, 2010). As King (2015, p. 16) explains "it also involves a loss of the many support structures that are crucial to the preservation of a person's sense of existence, self, and belonging within collective structures and processes". These experiences and effects of tribal disconnection socially and physically was a shared by many of the respondents.

Despite these ongoing issues of disconnection, all of the respondents were aware of their tribal affiliations. The respondents identified their local or out-of-area iwi and none solely self-identified as 'urban Māori', in terms of not knowing their whakapapa connections. Many of the marae respondents identified the affects or urbanisation and moving to Tāmaki Makaurau, either in their youth or recently as adults (R. S. Hill, 2012). One respondent (Interview, Group 2, Ruapotaka Marae, 3 August 2012) reflected on his reasons for moving in search of "'big jobs in the city', the freezing works and the 'place where the money is". Another respondent (Interview, Group 1, Ruapotaka marae, 27 June 2012) argued that their urban marae help to keep her connected back to her tribal home, "being so far away in the city, being far away from my own marae, there's that link with your marae and I guess that this marae Ruapotaka offered me that link back to my own marae". This respondent also spoke of her marae being relatively new, operating for thirty years, and that for a substantial period of that time the marae sat barren. Two respondents argued that urban Māori could affiliate with both their urban and traditional marae. This is because urban marae needed to welcome new members, regardless of tribal affiliations according to Wyn (Interview, Wyn, Nga Whare Waatea Marae, 21 June 2013). He challenged urban Māori embrace a new and urban marae: "invite them in to come in and be vibrant component of the marae as opposed to 'that's over there, and we've got our own marae'". Many of the respondents felt the marae had enabled them to form stronger connections to their family and community and were eager for other community members to also benefit from these connections. Community gardens within marae offer a means of putting down 'roots' (Wen Li et al., 2010).

Several respondents discussed features of their marae land in terms of ensuring effective use of available land, and concern of the current land limitations within their urban living environment (George, 2010). In Chapter 5, I briefly reviewed some of the ongoing land issues for urban marae, including the case study marae, these matters were also raised during our interviews. In terms of land limitations several respondents contended that their marae should have more land to expand their community to garden, not just for the benefit of Māori but also for the wider community. Almost all of the gardeners wanted to increase the size of their gardens, and thereby their produce variety and output. For example, Lionel (Interview, Lionel, Papatūānuku Kōkiri Marae, 24 May 2012) was particularly enthused about developing uses for kumara: "the one I'm trying to work out is 'Kūmara Ice Cream' … Kūmara bread, kūmara pancakes, and then a guacamole type kumara". Teri (Interview, Teri, Te Puea Marae, 24 October 2012) was keen to expand the capabilities of gardens: "will hopefully be self-sufficient a whole self-sufficient marae where we're only buying meats… like if I could I would

have wheat growing out there and a little mill to grind it". Interestingly, over half of the respondents wanted to sell their produce to external sources as a means of revenue source for their marae.

Two respondents noted that urban living often meant limited or no access to land to garden. As Rango (Interview, Rango, Mataatua marae, 24 October 2012) explained the situation of many urban dwellers and the lack of land access: "a lot of people ain't got that around their own house, they don't even have grass … I see a lot of people grow them in boxes and jars and … whatever space they've got, but it's … it's just not enough, it's not enough". Marae gardens could provide family and community members with an opportunity to work the land and grow their own food by the respondents. Other gardeners were disappointed that their marae was limited within their central township and many marae gardeners had to contend with contaminated or dumpsite (waste) land (see Chapter 5). Thirteen respondents spoke of the land issues encountered while developing their gardens. For example, issues such as: sewerage ponds; limited land; soil PH levels; polluted water; under-developed land; vacant community land; ex-dump site land, and air pollution from motorway cars. As Teri (Interview, Teri, Te Puea marae, 24 October 2012) spoke of their current land issues, "my thing was is because it was a dump site wouldn't all the stuff be good for it and because just where I am, the kitchen has been using that for a dump site for food scraps for about twenty years so when I dug it up it was beautiful soil so I just went with it". One marae (Ruapotaka) had seen a reduction in land availability due to the rebuilding of a community centre next door. Overall, the urban location for many of the case study marae placed restrictions of land availability and quality, therefore many of the marae contended ongoing land issues which were financially difficult to overcome. Yet, other respondents argued that regardless of financial pressures or limited land, marae land should be put to effective use for all marae members.

As, Delwyn (Interview, Delwyn, Makaurau Marae, 3 August 2012) summed up that effective use of land is also linked to marae sustainability:

> ... it wasn't so much from a financial perspective although that's the real benefit when you realise what the cost is and the freshness and the quality and the taste and all those other things that come along as benefit's but it's really about sustainability and also we had such a beautiful piece of land and it's so ... it's such a waste to not actually do something with it. So when we moved here, it was like, 'yeah I want to put an orchard in'

Although Delwyn's marae is considered urban by location, it was the only marae of this study that is situated away from a town centre and in more rural environment. Unlike the majority of study marae, Makaurau marae had nearby vacant land that they were endeavouring to utilise in the future. Another Makaurau Marae gardener (Interview, Anon. 1, Makaurau Marae, 27 June 2012) argued the same point: "land is sitting there doing nothing you know so let's use it and fruit trees they don't take as much work as a vegetable garden you know they kind of grow you do bits with them but you don't have to be there every day to be looking after them". Not all of the study marae had access to larger vacant plots of land, many of the respondents argued that it was important to utilise what they had to

their collective advantage. As discussed previously, Ngahuia (Interview, Ngahuia, Ōrākei Marae, 16 May 2012) alluded to the struggles her marae had by a colonial enforced relocation (refer Chapter 5). She inferred that because of their struggles, her marae had an obligation to utilise their land to its fullest capacity.

At the end of this section, I have demonstrated that urban marae provide a physical place for sociocultural connections for Māori. The environment dispossession for many Māori from their tribal homes has resulted in the increased importance of urban marae and its role in the reconnection and repossession of tribal lands and land-based wellbeing activities. Urban marae and community gardens offer Māori everyday therapeutic experiences of utilising and beautifying urban land, while contributing to a sense of belonging, and also enhancing social cohesion (P. King et al., 2015). For many of the respondents, their marae garden engagement served as a platform for the effective utilisation of their urban marae land while actively contributing to family diets and wellbeing.

9.5 Conclusion

In this final chapter, I have maintained my central argument that urban marae are integral sociocultural places for the development of cultural capacity and Māori wellbeing. I have shown that marae operate as multifunctional support for the enhancement of Māori family wellbeing, yet there are ongoing challenges to the sustainability of this role. The processes of colonisation and urbanisation continue to impact Māori cultural foundations and places of sociocultural wellbeing. Nonetheless, the continued and increased presence of urban marae signifies the flexibility and endurance of Māori to persevere in providing a communal place that supports and prioritise Maoritanga alongside family wellbeing. The respondents confirmed that many of the unique and comprehensive holistic characteristics of marae continued to encourage and enhance their active engagement. Marae were viewed as important safe havens for connecting with families and engaging in sociocultural experiences that were limited within their urban lifestyles. I showed that marae were also places of empowerment for Māori autonomy and cultural capacity, however, personal autonomy can be undermined. Though, marae and community engagement is undertaken with understandings of this prevailing cultural-collective ethos.

I demonstrated that marae are Māori health sites that can comprehensively support cultural-collective initiatives that are responsive to local contextual circumstances. Situated within Māori communities, marae are well positioned to have first-hand knowledge of the socioeconomic and structural barriers facing Māori. Marae members can draw from this knowledge to design, deliver and control wellbeing programmes that are culturally and contextually relevant. This includes developing wellbeing strategies that are linked to the recognition or advancement of Māori cultural foundations, while focusing on equity of health outcomes for all family members. Thus, I made the point that although not all of the marae were contracted by the government to provide Whānau Ora programmes, they already have long-term and existing experience as Whānau Ora providers that should have more funding support.

Of note, I confirmed that marae are everyday urban-indigenous therapeutic landscapes that enable multiple wellbeing experiences for Māori. Urban marae provide distinct opportunities for urban Māori to connect or reconnect with Māori culture, land-based and tribal sociocultural experiences. Combined with homelike and familiar features, urban marae are regarded as open and accessible places for Māori and wider community members. The community gardens were further viewed as an informal pathway for re-establishing marae and Māori values. Finally, and in view of all the marae discussions, I summarise that marae are crucial contributors to Māori autonomy, cultural capacity and family wellbeing, yet the reality is that neither marae nor community gardens are a priority for all Maori. Thus, my final argument is that marae-based initiatives are wide-ranging and potentially valuable strategies, but they can be only one of many health strategies involving Māori.

Chapter 10 Conclusion

Figure 18: Papatūānuku Kōkiri Marae 3

Panoramic overview of Papatūānuku Kōkiri Marae and gardens (2015)

10.1 Introduction

In this study, I have argued that culturally-loaded places have a distinctive role for urban-indigenous peoples because they comprehensively support the development of cultural efficacy and holistic well-being. These places are effective indigenous wellbeing settings or sites since they deliver cultural-collective initiatives that capitalise on sociocultural and localised environmental factors to provide therapeutic experiences. One of the most important features of these places is that they are primarily autonomous environments in which indigenous peoples can determine and engage in wellbeing activities. Thus, I positioned culturally-loaded places within urban-indigenous therapeutic landscapes since they are vital familiar sites for indigenous peoples to be amongst fellow indigenous peoples while connecting to their culture and undertaking health initiatives. Cultural wellbeing experiences are particularly important for an increasing urban-indigenous population who in some cases have limited access to their tribal gathering places and practices. I further argued that community gardens are an everyday health initiative that when situated in these settings can produce multi-faceted holistic benefits for indigenous peoples contributing to nutritional, social and cultural wellbeing. Hence, I highlighted the circumstances and workings of community gardens located within urban marae as a case study to explore the extent of their potential and role in Māori health and wellbeing. What I found is that marae food gardens are autonomous environments and activities that produced numerous benefits for the Māori respondents and wider community. The marae gardens were products and producers of cultural efficacy as the gardeners worked collectively to produce food for their family and marae, but more importantly to socialise and acquire a wide-range of knowledge.

Interestingly, socialising was identified by all of the gardeners as one of main influences and outcomes of their garden participation. Another highlighted influence was the invaluable opportunity to physically

work the land that connected them with childhood and tribal memories while actively producing fresh food to share. Aside from the benefits of food production the gardeners discussed features of their everyday gardening that included aspects of empowerment, intergenerational knowledge transmission, subtle activism, and localised empowerment. Yet, each marae and their gardeners struggled with social, economic and political challenges that affected the sustainability not only of their gardens but also the marae itself. It was apparent that the processes of urbanisation and neoliberal forces permeated each marae including their gardens, creating almost daily challenges. Nonetheless, the dynamism and resilience of each marae, and the Māori gardeners, to maintain their garden ultimately reflected their persistence for self-determination in their collective health and wellbeing. Ultimately, supporting marae in the provision of wellbeing initiatives also contributes to re-establishing and reinvigorating urban marae as centralised places of Māori culture, language and practices.

A secondary argument of this study is the necessity of applying cultural theoretical frameworks to understand and determine relevant approaches for improving indigenous peoples' health and wellbeing. I demonstrated that prevailing behavioural change theories and resultant health strategies involving indigenous peoples are limited because they focus on individualised motivations and outcomes, with little consideration of environmental influences that can either impede or improve their wellbeing. While some health theories and strategies have adapted to incorporate a combination of collective and cultural factors, they remain inadequate for indigenous peoples due to expectations of individual outcomes and accountability. Health promotion for indigenous peoples has also centred on information or education campaigns of single health messages which have proven to be ineffective. I also showed that recent developments in health promotion have evolved to encompass environmental factors such as health settings within their programme delivery. These health settings approaches aim to empower and utilise existing community-based resources to ensure more effective and appropriate wellbeing programs. Yet, in spite of these important efforts, the programs are predominately government initiated and controlled, which can then serve to undermine the autonomy of community groups. Governmental influence can also lead to neoliberal exploitation of the community settings including important resources held within. As a means of resolving significant health issues, cultural efficacy theory underpins indigenous health strategies that empower autonomy derived from cultural-collective initiatives and the effective utility of culturally-loaded places.

My findings demonstrated that community gardens provided an informal physical place for Māori gardeners to mobilise and accomplish collective goals. The gardens encompassed features of empowerment and autonomy as the gardeners' utilise their knowledge and skills to collectively grow produce and engage in localised initiatives. All of these features of the gardens actively increased the gardeners' cultural capacity and confidence. The importance of these health initiatives was the rewarding experience of achieving goals which empowered the gardeners to address other local issues beyond their gardens. Yet, gardening was an ordinary activity that increased family wellbeing and cultural efficacy contrasting with the often complex and ambitious governmental health initiatives that are imposed on indigenous communities. Overall, I showed that health strategies involving indigenous peoples must support an alternative approach that prioritises cultural-collective motivations and outcomes, and the environmental influences, such as culturally-loaded places, that support these

endeavours. My study confirmed my theoretical stance that cultural efficacy is a more relevant and applicable framework than self- or collective efficacy because it emphasises the main influences conducive for indigenous health improvement. Overall, in consideration of my two main study arguments as I discuss further below, my research affirmed that marae and community gardens have a distinctive contemporary role in supporting the development of urban-indigenous peoples' cultural efficacy and wellbeing. In the upcoming sections, I further discuss and summarise the main outcomes of this study.

Foremost, I reiterate my main research question:

> What are the preconditions for addressing indigenous health problems and to what extent can participation in community gardens on culturally-loaded places satisfy those conditions?

This is supported by the following objectives:

- To examine the relationship between cultural efficacy and everyday activities within culturally-loaded places;
- To identity and examine the outcomes derived from participation in marae food gardens and their implications for elevating indigenous wellbeing;
- To explore the importance of site and locational context in the delivery of effective and appropriate indigenous health promotion.

In Section 10.2, I provide a synthesis of the respondents' discussions. Section 10.3 highlights my contributions to the literature, while in Section 10.4 I describe the limitations of my research findings and provide some personal reflections my research. Section 10.5 outlines some suggestions for further research. Finally, in Section 10.6, I provide a brief concluding commentary.

10.2 Synthesis of empirical findings

Whilst many of my research discussions were specific to Māori and urban marae, they also help to address questions more broadly about what can be considered as cultural-collective approaches and the contribution of specific settings for indigenous wellbeing (see Chapters 7-9). The first objective of this study was to examine the relationship between cultural efficacy and everyday activities within culturally-loaded places. This objective underpinned two interrelated hypothesis of my study. First, that marae are a significant environmental influence for cultural efficacy beliefs and Māori wellbeing. Second, that efforts to improve cultural efficacy and wellbeing are not reliant on contracted or high-level health systems initiatives, but can be achieved through everyday cultural-collective activities such as community gardens supported by marae. While the gardeners were not asked directly to consider cultural efficacy factors or the role of the marae as a source thereof, I found strong indicators that cultural efficacy among the gardeners was enhanced through this ordinary and familiar activity of marae gardening. The gardens proved to be an information source for cultural capacity as the

gardeners spoke of interacting and learning from other gardeners. Witnessing fellow gardeners at work provided both mastery and vicarious experiences. The combination of gardening knowledge that included traditional cultural practices was identified as a significant outcome specific to marae gardens. Intergenerational knowledge transmission was attributed as both a leading influence and an outcome of marae gardening as the gardeners expressed their desire to share their knowledge and expertise among family members. Each marae provided a place for the gardeners and their families to access experiences and knowledge of both their culture and gardening. In this regard, accessing and utilising their marae provided an important cultural efficacy source of wide-ranging sociocultural experiences.

The informal composition of the gardens provided a casual means of increasing the gardeners' cultural efficacy beliefs. While at face value gardening represented a simplistic or ordinary wellbeing activity, the respondents revealed directly and indirectly that the gardens were an empowering place and activity of autonomy and sovereignty. This was *directly* apparent as they all discussed utilising their combined skills and knowledge to collectively plan, participate and control their gardens. Yet, it became *indirectly* apparent that a few of the gardeners were also engaging in subtle activism or understated sovereignty within their small plots of marae land. These gardeners were undertaking collective action to increase the control of family's health by maintaining the quality and quantity of their diets, and actively reaffirming or claiming marae land for use while also reinforcing Māori traditions. In this regard the gardeners were actively mobilising their collective capacities to address issues of food sovereignty. Together these features and benefits of marae garden engagement contributed to the support and development of cultural efficacy among the gardeners. My research showed that gardening and the ways in which the respondents engaged with socially through their shared activities can be conceptualised as everyday practices of wellbeing and being Māori. These practices were supported by Māori values and traditions, overt and subtle, which prioritises family health and wellbeing. The relationship between the ordinary activities of gardening within informal settings of the marae has shown to be contributory environmental factors in the development of Māori cultural efficacy among the gardeners.

The second objective of this study was to identify and examine the outcomes derived from active participation in the marae gardens and their implications for elevating indigenous peoples' wellbeing. This objective enables understandings based on the respondents' perspectives regarding the influences and results of their garden participation which can inform health systems of the results of Māori led-health initiatives. These preconditions for improved Māori health revealed the potential utility of marae as an appropriate health and wellbeing site. Interestingly, my research found that the gardeners' reflections of the wellbeing benefits of gardening within marae both strengthen and weaken an earlier contention of this thesis. My assertion and literature reviewed emphasised the wide-ranging importance of cultural factors, including settings and programs, as a fundamental support and requirement for indigenous peoples' holistic wellbeing (see Chapter 3). On the one hand, the gardeners supported my argument that marae gardens were a crucial cultural settings in urban centres in which they shared knowledge and practices. They confirmed that they enjoyed many of the sociocultural features and experiences associated with their marae gardens. Yet, on the other hand,

they demonstrated that it was not specifically the more traditional cultural features of marae that influenced their engagement or produce their intended outcomes, but rather social factors were more significant. My hypothesis that the cultural factors or foundations were a lead or primary motivation for garden engagement was not supported by the gardeners. Very few of the gardeners spoke of the cultural attributes of either the garden or the marae in connection to their engagement. Although this does not indicate or undermine that cultural factors may have influenced their engagement, it was difficult to determine as it was not always discussed in a tangible manner.

As I considered in Chapter Six, this lack of discussion concerning the cultural enticements and benefits of marae gardening could be due to several factors. To recap, I posited that with a Māori researcher among Māori gardeners on marae, participants may have felt less inclined to 'state the obvious' regarding mutually understood cultural wellbeing features and benefits of marae. Nevertheless, the gardeners emphasised that social connectedness was their main influence and outcome of community garden engagement followed by aspects of altruism and productivity. These experiences of altruism and productivity arose from the gardeners' wellbeing experiences of freely sharing food and knowledge which contributed to feelings of being productive and useful. The importance of socialising in urban centres for Māori can be linked to rapid urbanisation and the breakdown of Māori kinship communities resulting in both social and cultural isolation. Although simplistic, the implications of these discussions for future indigenous health initiatives emphasises the need to ensure that urban indigenous people have a specific indigenous place that enables opportunities to socialise, share and give among their fellow members. The socialising of the gardeners provided opportunities for the gardeners to form cultural relationships contributing to wellbeing outcomes of identity, pride and self-esteem. The marae and the experiences of collective gardening were important facilitators for their culture, a support for identity and wellbeing, and also providing a connection back to ancestors. The Māori gardeners expressed their enjoyment in the casual activity of gardening that provided a tangible means to actively contribute to the improved diet of their families and marae, and by doing so increased their self-worth and sense of accomplishment in helping others.

Finally, the last study objective was to explore the importance of site and locational context in the delivery of effective and appropriate health promotion. This objective underpinned the central argument of this study that marae have a distinctive contemporary role for urban-indigenous peoples as a comprehensive support for cultural efficacy and holistic wellbeing. First and foremost, marae functioned as urban-indigenous therapeutic landscapes by providing a cultural-collective setting and land-based health programs for the respondents. My discussions showed that the role of marae was not limited to the physical place and use of the land and buildings, but also included interpersonal engagement with tribal elders and experts. Accessing and utilising sociocultural factors located within the physical space of marae (re)connected and exemplified urban marae as a place of 'being Māori' and a focal point. Importantly, marae have an important role in Māori health because they can undertake a grounded cultural-collective approach to improving Māori health behaviours utilising local resources and skills existing within their communities. Many of the gardeners' spoke of understandings of current health problems prevalent within their families and community, and that

marae gardens could have a significant impact on their improved physical and nutritional health. In this regard, the potential role of their marae was highlighted as a means to utilise local knowledge and skills to address current local health issues. Yet, ongoing limited funding and participation issues for each marae have created many challenges in helping others.

Though not all the gardeners spoke of the importance of marae or their locational context, my observations and field notes affirmed that each marae had created their gardens based on the local needs of their Māori and wider community members. Across the marae this resulted in a range of gardens such as teaching gardens for teen mothers, horticulture certificate gardens, and family gardening plots. As a site for health promotion, each marae had many attributes that enable them to provide effective and locally responsive activities for Māori and the wider community. Most importantly, each urban marae provided a means for cultural, social, health and healing to occur within a Māori context. Alongside the marae-based benefits described above, the gardeners also identified the significance of environmental factors such as an informal and autonomous space. The gardens were identified as an informal space that was within, but separate from, the more formal areas of the marae. Gardeners could self-determine the extent of their marae involvement, for instance to largely remain with the informal setting of the garden or to occasionally 'cross over' to the formal marae atea. The gardens also occupied a unique position as an interface between the formal Māori cultural space and the external colonial urban environment. In this sense, the gardens offered the respondents a place of being Māori away from their urbanised lifestyle and at the same time separate to formal cultural protocols broadly associated with marae. This function of gardens can be crucial for Māori who as a result of urbanisation and colonisation processes are no longer comfortable or knowledgeable in the workings of marae (see Chapter 5). Yet, the respondents were also clear that while the marae represents a Māori and important and focal point of Māori cultural foundations there was more work needed to instil and (re)strengthen these values for other urban Māori families.

My discussions with the respondents confirmed that marae presented crucial physical sites in which Māori families can interact, reconnect, and reinforce Māori ways of being. Alongside the function of marae as a local gathering place for Māori they also have existing cultural-collective attributes that in the future health strategies can attract and encourage urban Māori to participate in wellbeing activities. Utilising marae and community gardens offered urban Māori an informal pathway of cultural (re)connection and (re)invigoration. In consideration of further Māori health initiatives, the holistic features and cultural foundations of marae can complement and comprehensively support Māori health strategies. For the most part, this research confirmed that marae are an integral representation of Māori culture and a tangible place for Māori to access and draw on a multitude of cultural-collective factors. This research also exposed the reality of gardens that despite their many therapeutic qualities for the gardeners they were also tenuous spaces. All of the gardens suffered from a combination of localised issues and also external governmental constraints such as lack of participation and funding. The gardens and gardeners also endured neoliberal practices, but they simultaneously reinforced and resisted neoliberalism. These difficulties served to underpin the resilience and resolve of marae and Māori in becoming inventive in acquiring their own funds and resources, but this was problematic because it may justify further dereliction of governmental responsibility for Māori wellbeing and

supporting marae. Still, the ongoing struggles for sustainability can deter both the gardeners and marae from continuing with the garden, despite the obvious benefits for family wellbeing. Ironically, these struggles can be viewed as generating Māori cultural capacity to mobilise and address local community issues, yet they can reduce cultural efficacy as these difficulties become increasingly challenging to overcome.

Overall, the empirical findings of this study have shown the potential and reality of urban marae as health delivery sites. These findings support my central argument that urban-indigenous community gardens can be viewed as a central source and support of cultural efficacy and wellbeing for indigenous peoples. The discussions of marae garden engagement demonstrated that this cultural-collective activity supported Māori autonomy and cultural capacity. Indeed, the respondents' marae garden engagement was fundamentally motivated by their collective determination to make a direct and indirect stance for their collective holistic wellbeing. Marae have an important role because they are empowering environments that support the autonomy of its inhabitants. The discussions with the marae respondents affirmed that efforts to improve Māori wellbeing need to be carefully considered to include both local environmental and cultural-collective factors, and that marae provide a vital and distinct role in meeting this function. The challenges faced by marae in sustaining membership in urban centres emphasises the diverse circumstances and realities of urban Māori and that marae are not panacea for all Māori. Nevertheless, my research has highlighted the role of marae as a crucial support for wellbeing initiatives and raised important implications regarding how to design programmes and utilise urban marae to facilitate improved Māori health and wellbeing.

10.3 Key contributions to the literature

In this section, I highlight the key contributions my research has made to the various literatures about approaches to understanding and determining improved indigenous health. I demonstrate how some literatures have been supported or challenged by my research. Firstly, my research has shown how health systems have advocated for more culturally congruent and empowerment approaches involving indigenous peoples, but they have fundamentally failed to effectively facilitate and support these approaches with indigenous communities. Health promotion efforts have resulted in an often confusing mix of approaches including: culture-centred; individual outcomes; single health message; quantitative; and paternalistic. These approaches have expectations of drastic individual and collective health changes, yet ignore the many social determinants that affect everyday lives. My respondents' discussions confirmed that the appropriate selection of indigenous 'health settings' is foremost the most important support for wellbeing initiatives. Marae, for example, encompass numerous culture-collective features based on social, cultural and environmental wellbeing. They are also empowering places of autonomy that not only contribute to improved health, but also cultural capacity to address immediate and wider health issues. In this regard, health initiatives are not 'done to' marae, but rather 'done with' or 'done by' them. At present, health strategies have still require further development, rather than placed into indigenous communities with little regard for context. Broadly, these westernised or conventional approaches do not reflect the diverse circumstances of indigenous

peoples. Hence, the health and wellbeing of indigenous peoples remain of poorer quality than their non-indigenous counterparts. Indigenous health research has consistently demonstrated the need for localised and culture-collective approaches, though fundamental issues remain regarding indigenous health autonomy. I suggest that other literatures need to be more aware of the autonomous features of culturally-loaded places that ensure the incorporation of culture, social, composition, and settings factors in the design and delivery of initiatives that influence indigenous people's acceptability, support and engagement.

Secondly, as discussed in Section 10.1, health frameworks have limited applicability for indigenous peoples due to their individualised foundations and lower prioritisation of environmental influences. The importance of moving beyond Bandura's (1997, 2000a) constructs of self- and collective efficacy was supported by the respondents' discussions that prioritised cultural-collective features linked to their marae environment and garden engagement. Indeed, unique to culturally efficacy development is the utilisation of environmental factors and associated cultural collective resources as an equal influences for indigenous peoples. Cultural-collective approaches to health are reliant on the specific features of culturally-loaded places that are not readily available at other locations within urban contexts. My findings have challenged predominant behavioural research that identifies individualised motivations and influences for engaging in health change activities. Though this does not undermine individual autonomy in health and wellbeing, it recognises the diversity among indigenous peoples and that cultural-collective influences have a strong influence and priority. The utilisation of cultural efficacy theory in this research supports literature that emphasises the importance of more culture-centred framework to determine and understand both cultural and collective influences for indigenous peoples.

Thirdly, this study supports literature concerning urban-indigenous therapeutic landscapes. While there is abundant literature regarding therapeutic landscapes, at the time of this study, there has been limited research highlighting Wendt's (2012a) urban-indigenous therapeutic landscapes. Throughout this thesis, I have aligned the function and utility of urban marae with Wendt's study of Urban Indian Health Services. My research has demonstrated that urban marae are therapeutic landscapes for Māori health service delivery, not just in a physical sense but also due to their relational aspects. In particular, their utility for Māori as a place that cultural and collective values are experienced lived and enacted. Engagement with marae provides experiences of cultural connectedness and reinvigoration that includes the recognition of early times prior to processes of colonisation and urbanisation. Yet, marae are not without internal tribal challenges highlighted by Wendt. Nonetheless, marae provide crucial access for urban Māori to significant cultural foundations such as experiences of sociocultural practices and encounters. Situating health promotion within urban-indigenous therapeutic landscapes ensures ease of access to these vital holistic experiences and services. The contribution of my study to this current literature is the emphasis on autonomous environments that support the effective delivery of health services. Notably, marae are a culture-centred foundation that support Māori wellbeing, providing nurturing experiences from land-based interactions that also increase cultural knowledge, identity, and belonging. Current literature requires further research of culturally-loaded places and the extent of their wellbeing contributions and outcomes. This includes reviewing current efforts to reconnect urban-indigenous peoples with their cultural foundations.

Last, this study supports community gardens literature about the multiple benefits of active engagement. All the gardeners spoke of their enjoyment of undertaking a familiar, ordinary activity that linked generations. There was little disagreement between my findings and current literature that has reviewed the comprehensive sociocultural benefits, including land-based initiatives and interactions for indigenous peoples' wellbeing. Nonetheless, my discussion extends current knowledge regarding the more political nature of gardens. As I have previously mentioned, although gardening is an everyday casual activity of cultural-collective engagement, this belies its additional function as a politicised activity of indigenous autonomy and sovereignty. The marae gardens were sites of subtle activism in food sovereignty, alternative food movements, decolonising diets and self-determination in health. These discussions supported current literature regarding food security challenges for urban-indigenous peoples (Cidro et al., 2016; Gendron et al., 2016). The gardeners contributed to the continuance of knowledges and practices regarding traditional foods. Notably, this study also contributes to emerging literature that highlights the dichotomous circumstances of gardens as both resisting and reinforcing neoliberalism. Aside from food production, the gardeners directly and indirectly demonstrated that their gardens were active political sites for revitalising cultural connectedness and continuity in urban centres. These findings support Corntassell's (2012) assertions that indigenous cultural revitalisation and self-determination can be upheld in everyday practices of resurgence and decolonisation. These practices, such as marae food gardening, are concerned with reconnecting with traditional tribal lands, cultural practices, and communities, while centring on reclaiming, restoring, and regenerating cultural-collective relationships. Overall, viewing community gardens as sites of Māori autonomy and sovereignty enables a richer and more complete understanding of community gardening and of its potential contributions to understandings of Māori activism, community, democracy, gardening and culture.

10.4 Limitations of the study and personal reflections

This section discusses some of the limitations of my research and offers some of my personal reflections. The respondents in this study represented a small section of the members of their marae. The richness of my data was largely dependent on those with whom I could make meaningful connections, those who were willing to talk to me at length, and their interest in the topic matter. For many reasons, the respondents varied and fluctuated along this scale. Hence, some views may not be fully represented or reflections of an in-depth nature may be limited. Much can be attributed to time constraints which often limited meaningful connections, and this could be viewed as a limitation of the study. With more time at each marae, I may have been able to conduct additional or extended interviews with some of the respondents. This may have put some of the respondents more at ease, to talk more broadly and to contemplate more comprehensives reflections. I acknowledge that reliance on initial interview data from several respondents may be viewed as restrained because in some instances I conducted only one interview with them and with no follow up. For example, as mentioned in Chapter Six, more time and interaction prior to our first interviews with the homeless men may have solicited more in-depth and considered responses. As time progressed, I found that many of the

gardeners were seasonal and over a relatively brief period of a few months some had left the area and marae for places unknown and could not be revisited.

Another possible limitation was that the final analysis of the data was an individual effort. I reviewed and analysed all the interview transcripts, field notes, and any other data collected during fieldwork and follow-up visits data. Had data coding been done collaboratively, the analysis of the data may have taken a different shape; however, this thesis is based on my analysis and interpretation of the data. My analysis of the data may have limited the discussions and findings to my biases. Yet, with the guidance of my supervisors I was able to more critically view marae within contemporary neoliberal and neo-colonial contexts. This resulted in determining the difficult realities of the everyday lives of Māori within these contexts which permeated all key themes identified in the research. The focus of this study was factors concerning Māori health and urban marae. Hence, my interactions and observations of the gardeners' were limited in this study to their participation in the gardens. In this respect, other areas of their everyday lives including additional marae participation were not explicitly included in this study. Expanding the scope of the study in these areas may have been useful in terms of further understanding and linking sociocultural living circumstances and marae involvement. Further to this, I did not explore concepts of empowerment that transferred beyond the gardens and marae such as into their homes and within their families. It may have also been useful to speak with marae members who did not partake in any capacity in the gardens. However, despite these limitations, and ways in which the scope of the study could have been extended, the data collected was in abundance and sufficient for the analysis presented in this thesis.

Of personal conflict, were the limitations of restricting the data to predominately gardening related insights because several respondents spoke broadly about their history and everyday life both around the marae and their homes. For example, several of the elder respondents spoke extensively about the history and background of their marae. Fortunately, as a prerequisite of this study, I was able to present the transcripts back to these members not only for checking but also so they could retain a copy. A further personal conflict, as mentioned in Chapter One and Chapter Six, is my personal interest in supporting and securing the future of marae in the everyday lives of urban Māori. This research has significance for my urban marae and others as we all struggle to reinforce the cultural prominence of marae and affirm their contribution to holistic wellbeing. As mentioned earlier, I often risked fostering a romanticised or naïve impression of urban marae and their role in Māori health. Yet, while I am an avid supporter of urban marae, this is tempered with personal understandings of the contentious internal workings of marae. Thus, I have tried to consistently balance this potential naïve impression of marae by presenting some of the more common experiences and associated difficulties. In addition, I have endeavoured to make it clear that the issues for increased utility of marae as health sites faces difficulties due to the lack of engagement from Māori and non-Māori. Moreover, marae are clearly not a priority or a necessity for all Māori. A general consideration of the role and utility of marae was provided and may be generally applicable because this highlights one solution among many.

As a final remark, it is important to acknowledge that much of the inspiration and motivation for this work derived from the vision of an improved future for urban marae and Māori wellbeing. However, it is

equally important to understand that many of the literature and results in this work are not limited to an indigenous context. The results about the development of cultural efficacy provide insights into empowerment of indigenous peoples. Similarly, the considerations with respect to marae as indigenous health settings and promotion venues are likely to be applicable to other indigenous groups. Thus, even though effective utilisation of urban marae was a motivation for this thesis, its impact is likely to transcend beyond this specific environment. Despite these limitations, my study nonetheless makes a number of important empirical, theoretical, and methodological contributions to the field of indigenous and Māori health and wellbeing. This study can serve as an impetus for health systems and marae to collaborate and develop cultural-collective programs to address health disparities within Māori communities. Marae can help overcome many local educational, economic, political and social obstacles in the everyday lives of Māori. Certainly, urban marae have the potential to help improve the wellbeing of Māori families alongside contributing to cultural connectedness and reinvigoration, and becoming a leading change agent autonomy and sovereignty in health.

10.5 Recommendations for future research

This study highlighted several potential avenues for further research. Broadly, this thesis highlights the need for further exploration within indigenous contexts of their utilisation of specific healthcare settings. While I have only briefly reviewed international examples of indigenous studies that emphasise the role of place and health, there remains a further need to provide understandings and examples of the practice of culturally-loaded places and their capacity to deliver wellbeing initiatives. Notably, there is a need to provide further in-depth studies of the role and utility of marae, rural and urban, as health sites. Hence, I maintain there remains a gap in the comprehensive exploration of the practice of urban marae autonomy and sovereignty. Specifically, research that focusses on the multi-level workings of an urban marae as it delivers both its own programs and governmental contracted programmes targeting Māori family wellbeing. Several marae in this study provided a wide range of wellbeing activities in addition to their gardens, some of which had larger participation and involvement. These marae were actively empowered to design, deliver and control many of these programs. The progression of this thesis work requires an in-depth understanding of the practice of autonomy within marae. This will involve taking a comprehensive and critical lens exploration of autonomy that includes an analysis of systemic and structural factors that either support or undermine the expression of autonomy by urban marae. Notably, describing and analysing the ways in which indigenous self-determination is inhibited by colonial structures and processes. Within urban marae communities are current practices and initiatives that with government funding can be sustainable and improve Māori health outcomes. The impact on health policy and provision of services could be evidenced in the lessons learned from empowerment of indigenous communities, who have grounded and first-hand knowledge of what constitutes wellbeing for their people and how this can be achieved.

Further research can contribute to knowledge of urban-indigenous therapeutic landscapes addressing the increasing needs of urban-indigenous population groups. At a community level the reality is there are many challenges remaining that need to be addressed on a national level before the goals of self-

determination in health care and health empowerment will be fully realised. Other areas recommended for future study include the review of cultural-collective approaches as exampled in differing health initiatives. This includes a focus on health strategies and policies that address family health and wellbeing as a collective issue rather than an individual challenge. Of personal interest, at the completion of this study, was the importance and complexities of indigenous food sovereignty movements in urban centres. While Moeke-Pickering (2015) has made some noteworthy contributions in New Zealand, the dearth of Māori literature on this subject indicates the need for further research. It became apparent that I only skimmed the surface reviewing and enquiring from the gardeners regarding their food sovereignty efforts. Future research can be undertaken to recognise the role of marae gardens within food sovereignty movements, as exampled in Lionel's argument that Māori need to move away from colonial control of food intake and sources. The international significance of indigenous community gardens is evident in their role linked to indigenous sovereignty, specifically in relation to food, traditions, and land ownership.

10.6 Conclusion

The results of this study suggest that social factors play a significant role in motivating urban Māori to attend a marae-based health initiative. Based on the research, I suggest that having a Māori-led health initiative within marae can increase Māori engagement. Health promotion within marae can involve the entire family and result in a greater impact of the initiative, while also contributing to the empowerment of autonomy and sovereignty. There are strengths and abilities already existing in urban-indigenous communities, and health behaviour change is often subtle and easier facilitated in groups. Cultural efficacy development in this study was shown to emerge through social relationships and everyday activities. It was enacted and experienced communally rather than provided to individuals. Understanding indigenous wellbeing in this way, as shared experiences in everyday practices, enables a different approach to be taken to the provision and design of health promotion strategies. The Māori gardeners of this study affirmed the utility of marae as a place to socialise, learn and share with each other and through this for themselves. Despite the efforts of the marae and the gardeners involved in this study, they all struggled with ongoing participation and commitment from other Māori families. Concerns about future sustainability in terms of funding, and the limited number of Māori families attending marae events were expressed by the respondents. Importantly, cultural-collective initiatives situated within indigenous peoples' communities' offers another option for health systems to address the diverse circumstances and requirements of indigenous peoples today. The respondents showed that developing cultural efficacy and wellbeing did not require elaborate external solutions, but in fact, could be sourced from urban marae and everyday activities that empowered and built their capacity. Ultimately, marae and community gardens are a comprehensive health promotion initiative with multiple holistic benefits that must be considered as just one of many viable Māori health strategies.

Glossary

Aotearoa	(Location) Māori name for New Zealand.
Atua	(Noun) God(s).
Hinengaro	(Noun) Mind, thought.
Hui	(Noun) Gathering, meeting.
Iwi	(Noun) Tribe
Kamokamo	(Noun) Squash, fruit of imported gourds.
Kanohi-ki-te-Kanohi	(Stative) Face To Face, in person.
Kaumātua	(Noun) Elder – a person of status within the whānau.
Kaupapa Māori	Kaupapa – (Noun) Topic, theme.
Kawa	(Noun) Marae protocol, customs.
Kei Te Pai	(Phrase) "It's good"
Koha	(Noun) Gift, offering, donation.
Kōhanga Reo (Kōhanga)	(Noun) Māori language preschool.
Kōrero	(Noun) Narrative, story, account, discussion, conversation, discourse or statement.
Koro	(Noun) Elderly Man, grandfather.
Koroua	See Koro.
Kōtiro	(Noun) Girl.
Kuia	(Noun) Elderly Woman, grandmother.
Kūmara	(Noun) Sweet potato.
Mahi	(Noun) Work.
Mana Whenua	(Noun) Territorial Rights.
Manaakitanga	(Noun) Hospitality, kindness, generosity, support.
Māoritanga	(Noun) Māori culture, Māoriness.
Māra Kai	(Noun) Food Garden. Also known as 'Maara kai'
Marae	(Noun) The complex of buildings around the marae
Maramataka	(Noun) Māori lunar calendar.
Mihimihi	(Noun) Speech of greeting, tribute – introductory speeches at the beginning of a gathering.
Mokopuna	(Noun) Grandchildren.
Pakeke	(Noun) Adult.
Pānui	(Noun) Public notice, announcement.
Papakāinga	(Noun) Original home, home base, village, communal Māori land.
Papatūānuku	(Personal Name) Earth, Earth mother.
Pōwhiri	(Noun) Welcome ceremony on a marae.
Pūtea	(Noun) Fund, finance, bank account, sum of money.
Pūhā	(Noun) Perennial sowthistle.
Ranginui	(Personal Name) Atua of the sky.
Rāua	(Pronoun) they, them (two people).
Rūnanga	(Noun) Council, iwi authority.
Taiohi	(Noun) Adolescent.
Tāmaki Makaurau	(Location) The Tāmaki Makaurau region stretches from the South Kaipara in the north to the southern reaches of the Manukau Harbour and covers more than 5,600 square kilometres.
Tamariki	(Noun) Children.
Tane	(Noun) Male.
Tānemahuta	(Personal Name) Atua of the forests and birds.
Taonga	(Noun) Treasure, anything prized.
Tangata Whenua	(Noun) Indigenous people of the land.
Tangaroa	(Noun) Atua of the sea and fish.
Tangihanga	(Noun) Māori funeral
Taura Here	(Noun) Urban kinship group.
Te Puni Kōkiri	(Organisation) Te Puni Kōkiri monitors policy and legislation, and provides government with high quality policy advice.
Te Reo	(Noun) The (Māori) Language
Te Tiriti o Waitangi	(Founding Document) The Treaty of Waitangi.
Te Waipounamu	(Location) South Island of New Zealand
Te Whare Tapa Whā	(Theory) Māori Model of Health.
Tikanga	(Noun) Custom, protocol.
Tūrangawaewae	(Noun) Place where one has rights of residence through and belonging through kinship and whakapapa.
Wāhi Rongoā	(Noun) Place of Healing
Wahine	(Noun) Female.
Waka	(Noun) Canoe.

Wānanga	(Noun) Seminar, conference.
Wairua	(Noun) Spirit, soul.
Ngā Pae o te Māramatanga	(Organisation) Māori Centre of Research Excellence
Whaea	(Noun) Mother, aunt, aunty.
Whakatau	(Verb) To welcome officially, welcome formally
Whakapapa	(Noun) Genealogy, lineage, descent.
Whakawhanaungatanga	(Noun) Process of establishing relationships, relating well to others.
Whānau	(Noun) Extended family, family group, a familiar term of address to a number of people.
Whānau Ora	(Health strategy) a Māori health strategy based on family and cultural values.
Whanaungatanga	(Noun) Relationship, kinship, sense of family connection
Whare	(Noun) House.
Wharenui	(Noun) Traditional Meeting House.

Sourced from Māori Dictionary (Te Reo Māori App), tpk.govt.org

Terminology

Throughout this thesis, I repeatedly employ terms that can be initially identified as broadly descriptive, thus warrant further explanation. The three main terms are: cultural-collective approaches, culturally-loaded places, and health systems. Although each of these terms is self-explanatory, it is important that I clearly establish what each term represents and encapsulates as I have employed them. First, 'culturally-loaded places' is one of my main terms utilised in this thesis. While I occasionally interchange this description with similar terminology such as cultural environments and culture-centred settings, they are all describing the same entity. From the very beginning of this thesis I struggled with a comprehensive yet simple term to adequately identify places of cultural significance or cultural relevance for indigenous peoples. As an example, I did not employ the term 'cultural significance', as I felt it had connotations of stagnated or conserved artefacts that were no longer places of culture in practise. After much consideration, I appropriated Wen Li's (2010, p. 794) term of culturally loaded places which she defines as: "textured by human movement and action, identities and relationships". These features have been attributed by Māori academics as some of the main characteristics of marae for Māori (see George, 2012; R. Walker, 1992). I posit that international indigenous examples of culturally-loaded places include sweat lodges, longhouses, and healing lodges (see further Chapter 2).

The second broad descriptive term is 'cultural-collective', generally applied as a health approach. Again, I found difficulties in selecting a definitive term that incorporated and facilitated both aspects of cultural and collective health requirements. Initially, the term 'cultural' approach adequately summed up the inclusion and recognition of indigenous cultures. Also, health literature predominately describes indigenous health programs and services as 'culturally appropriate' (Kendall & Barnett, 2015) or 'culture-centred' (Dutta, 2007). Still, I perceived limitations to employing any of these terms for this study due to the implication that only culture values and concepts were prioritised in these approaches. This is because not only are the cultural foundations of indigenous community's crucial components of health promotion, but also the more collective factors such as family and improving the wellbeing of others. That is not to say, that cultural approaches are not centred or interrelated to family wellbeing, I wanted clear terminology. Identifying specific health approaches with the joint term cultural-collective is my distinction of incorporating cultural foundations and family or group factors. The last predominant term only requires a brief explanation is 'health systems'. This term broadly encompasses governmental and wider community health organisations including people, institutions, and resources that deliver health care services to meet the health needs of target populations. For example, New Zealand health systems are described as complex and include the Minister of Health who is supported by the Ministry of Health and its business units. The day-to-day business of this health system is administered by District Health Boards who plan, manage, provide and purchase health services (Ministry of Heallth, 2017). Health services include primary care, hospital, public health, and services provided by other non-government health providers including Māori and Pacific providers.

Last, I briefly explain of the writing conventions located in my work. In the body of the thesis where Māori words are used in the text for the first time a translation follows immediately after in brackets. A glossary is also provided. Where there is need for further explanation or definition of a term, especially concerning concepts, I provide a footnote additional meaning. As a personal choice, Māori words used in this thesis are not italicised or in bold to ensure both a fluid document to read and the normalisation of Te Reo Māori (Māori language). I have also chosen not to capitalise 'indigenous', once again as a personal preference. Finally, my use and discussion of international literature that broadly discusses similar aspects of indigenous cultures is purposely not identified to a specific group but instead 'indigenous'. This is only applied to literature or studies that are similar across indigenous peoples. Yet, when authors or concepts are specifically attributing a cultural group then I employ their terminology such as Aboriginal, First Nations, Native American, Inuit, Koorie, and Métis.

Appendices

Appendix A: Marae Information Letter

School of Population Health

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Te Kupenga Hauora Māori
Cnr Morrin Road & Merton Road, St Johns
Telephone: 64 9 373 7599

The University of Auckland
Private Bag 92019
Auckland, New Zealand

2012

LETTER OF INTRODUCTION

Principal Investigator:
Ko Ngāti Kahungunu te iwi
Ko Rhys Jones taku ingoa

Senior Lecturer
Te Kupenga Hauora Māori
School of Population Health
University of Auckland

Co-Investigator:
Ko Kāti Mamoe te iwi
Ko Brad Coombes taku ingoa

Senior Lecturer
School of Environment
University of Auckland

Co-Investigator:
Ko Australia te whenua
Ko Alex Macmillan taku ingoa

Senior Lecturer Environmental Health
School of Population Health
University of Auckland

Māori Research Fellow:
Ko Ngāti Awa te iwi
Ko Kimiora Raerino taku ingoa

School of Population Health
University of Auckland

Marae Food Gardens

Nā te māra kai te whakamātau a oranga - From the garden wellbeing is tasted

Tēnā koutou katoa,

Thank you very much for providing our research group the opportunity to present our research study request to your marae committee Hui.

Food gardens on marae are likely to have a wide range of benefits for physical, social, cultural and environmental wellbeing. However little is known about the overall benefits of participation in marae gardens for whānau, hapū, iwi and the marae community itself. We would like to interview marae food garden participants to assess the positive outcomes of participation in marae food gardens to Māori wellbeing, based on experiences of marae communities in urban Tāmaki Makaurau. We wish to identify the most important wellbeing outcomes for participants, assess how well marae food gardens are helping to achieve these outcomes, and explore how particular aspects contribute to improving Māori wellbeing.

We would like to invite your marae and marae whānau to be a part of our new study, for your marae this will mean:

1. Agree to be part of this research project
2. Provide our research team with information about your marae, so we can create a history (or profile) of your marae and food garden

3. Identify a minimum of five whānau members (from separate whānau) who actively participate in your food garden, to be interviewed individually and as part of a focus group
4. Agree to our research team observing active participation of the participants in the marae food garden. This may include observing participants participation in planting and harvesting activities. We may also request permission to take photographs – to document active participation for future research publications. Identifiable photographs of participants will not be taken without the written permission of the participant.
5. Agree to our research team conducting a hui at your marae to discuss the research results (at the completion of the interviews and analysis)
6. Participate (optional) in an Open Day hui with other urban marae participating in this study, to share results and create opportunities of whakawhanaungatanga and mohiotanga between marae communities and other interested community groups

Participation is voluntary, and participants can withdraw from the study at any time. Marae, as research sites, also have the option to withdraw from this study. If marae elect to withdraw from this study, then all associated marae participants will be withdrawn. Participants invited to take part in this study may decline this invitation, without the need to give a reason, if they do not wish to participate. To decline this invitation, potential participants can advise the research team directly by email or phone – or they may contact your Marae food garden representative.

Interviews will be conducted and transcribed by a Māori researcher and transcriber who are familiar with tikanga and te reo. A request can be made for an interviewer who is fluent if the participants like to be interviewed in te reo. The direction the interview takes would be largely in the hands of the participants and the topics discussed would be those of most concern and interest to the participants. Interviews will be recorded. These recordings will be transcribed, and content will be kept confidential. If a transcription service is used they will be bound by a strict confidentiality agreement.

During the individual interviews, the recording can be stopped at any time at the request of the participants. Following the interview, we will provide a copy of the transcript to read, edit and send back to us within 30 days. This is an opportunity to withdraw or clarify any information. During the focus group interviews, it will not be possible to stop recording, however, there is an option to leave the focus group during the taping or not answer the question. Similar to the individual interviews, we will provide a copy of transcript. However, withdrawal of information will not be possible. This is because if one participant edits or completely removes their input there may be large gaps in the data that may not connect with the other parts of conversation. In the review of the focus group transcripts, participants have the option to edit identifiable information or names, and information that is not directly relevant to the study.

Each marae participating in this study will be identified and profiled in the research reports. Participants may request to be identified and named in the research reports or be identified in a generalised (anonymous) manner, e.g. Garden Project Member 1. If participants elect to remain anonymous, we will endeavour to ensure that they will not be identifiable in any reports or use of quotes, however we cannot completely guarantee they not be recognised. All data (including digital files and written material) will be kept in secure storage at the University of Auckland for 6 years before being destroyed.

Principal Investigator contacts	PhD Supervisor contacts
Rhys Jones rg.jones@auckland.ac.nz (09) 373 7999 extn. 86278 Te Kupenga Hauora Māori School of Population Health Private Bag 92019 Auckland	Brad Coombes b.coombes@auckland.ac.nz (09) 373 7599 Ext 88455 School of Environment Private Bag 92019 Auckland

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Office of the Vice Chancellor, Private Bag 92019, Auckland. Tel: 373 7599 extn. 83711

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 23 AUGUST 2011 FOR 3 YEARS REFERENCE NUMBER 2011/392

Appendix B: Respondent Information Sheet (Combined)

School of Population Health

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Te Kupenga Hauora Māori
Cnr Morrin Road & Merton Road, St Johns
Telephone: 64 9 373 7599

The University of Auckland
Private Bag 92019
Auckland, New Zealand

2012

INFORMATION SHEET

Principal Investigator:
Ko Ngāti Kahungunu te iwi
Ko Rhys Jones taku ingoa

Senior Lecturer
Te Kupenga Hauora Māori
School of Population Health
University of Auckland

Co-Investigator:
Ko Kāti Mamoe te iwi
Ko Brad Coombes taku ingoa

Senior Lecturer
School of Environment
University of Auckland

Co-Investigator:
Ko Australia te whenua
Ko Alex Macmillan taku ingoa

Senior Lecturer Environmental Health
School of Population Health
University of Auckland

Māori Research Fellow:
Ko Ngāti Awa te iwi
Ko Kimiora Raerino taku ingoa

School of Population Health
University of Auckland

Project Manager
Ko Ngāti Porou te iwi
Ko Panapa Ehau taku ingoa

School of Population Health
University of Auckland

Marae Food Gardens

Nā te māra kai te whakamātau a oranga - From the garden wellbeing is tasted

E te rangatira, tēnā koe,

At the University of Auckland, School of Population Health, we are exploring the benefits of active participation in marae food gardens for whānau, hapū, iwi and marae hapori.

Food gardens on marae are an excellent example of a health promotion intervention that can have wide-ranging benefits for physical, social, cultural and environmental wellbeing. However little is known about the overall benefits of participation in marae gardens for whānau, hapū, iwi and the marae community itself. We would like to interview marae food garden participants to assess the positive outcomes of participation in marae food gardens to Māori wellbeing, based on experiences of marae communities in urban Tāmaki Makaurau. We aim to identify the most important wellbeing outcomes for participants, assess how well marae food gardens

are helping to achieve these outcomes, and explore how particular aspects contribute to improving Māori wellbeing.

Understanding the beneficial outcomes of participation in urban marae food gardens will contribute valuable knowledge about the holistic outcomes of marae food gardens for whānau, hapū, iwi and hapori. The overall intention of this study is to understand and identify the positive impacts of active participant in marae food gardens and transfer this knowledge to other marae throughout Tāmaki Makaurau (and Aotearoa).

You are invited to take part in this research by agreeing to a two hour single interview and one focus group meeting lasting approximately three hours. Your participation is voluntary, and you can withdraw from the study at any time. You can also withdraw any information given up to the date of your withdrawal, up until 30 days after having been provided with the transcript of your interview. Marae, as research sites, also have the option to withdraw from this study. If marae elect to withdraw from this study, then all associated marae participants will be withdrawn.

Interviews will be conducted and transcribed by a Māori researcher and transcriber who are familiar with tikanga and te reo. You can request an interviewer who is fluent if you would like to be interviewed in te reo. The direction the interview takes would be largely in your hands and the topics discussed would be those of most concern and interest to you. Interviews will be recorded. These recordings will be transcribed, and content will be kept confidential. If a transcription service is used they will be bound by a strict confidentiality agreement. During your interview, the recording can be stopped at any time on your request. Following the interview, you will be provided with a copy of your transcript for you to read, edit and send back to us within 30 days. This is an opportunity to withdraw or clarify any information.

Each marae participating in this study will be identified and profiled in the research reports. A list of participants will be provided in reports; however specific comments and ideas will be ascribed to the group rather than particular individuals. Participants may request to be identified and named in the research reports or be identified in a generalised manner, e.g. Garden Project Member 1. You have the option to remain anonymous. All data (including digital files and written material) will be kept in secure storage at the University of Auckland for 6 years before being destroyed.

This research has been funded by the Health Research Council, Rangahau Hauora Māori grant (11/623). Ethical approval has been given by the Auckland University Human Ethics Committee.

Your perspectives on the overall benefits of active participation in marae food gardens would be greatly appreciated. **We will be providing koha for those interviewed in the form of a voucher and a plant.**

This project will largely benefit from ongoing consultation with each marae and participants, and we will encourage participation in the review of research results and the descriptions of the food gardens. The results of the research will be disseminated to all participants. This project also includes a doctorate for the Māori researcher Kimiora Raerino, upon request you will be emailed either a summary of the research findings or an electronic copy of the entire thesis. Hui will be organised to discuss the findings of the research with each urban marae involved in the study. Additionally, three Open Day Hui for all participants and interested communities will be held to communicate the provisional findings of the study and to provide an opportunity for communities to use and discuss the result, to share experiences and provide feedback to the researchers.

Thank you very much in advance for your participation in this project.

School of Population Health

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Te Kupenga Hauora Māori
Cnr Morrin Road & Merton Road, St Johns
Telephone: 64 9 373 7599

The University of Auckland
Private Bag 92019
Auckland, New Zealand

2012

RĀRANGI MARAU

Te Tino Kai-Wherawhera:
Ko Ngāti Kahungunu te iwi
Ko Rhys Jones tōku ingoa

Kaiako Matua
Te Kupenga Hauora Māori
School of Population Health
Te Whare Wānanga o Tāmaki Makaurau

Hoa Kai-Wherawhera:
Ko Kāti Mamoe te iwi
Ko Brad Coombes tōku ingoa

Kaiako Matua
School of Environment
Te Whare Wānanga o Tāmaki Makaurau

Hoa Kai-Wherawhera:
Ko Ahitereiria te whenua
Ko Alex Macmillan tōku ingoa

Kaiako Matua Hauora a Taiao
School of Population Health
Te Whare Wānanga o Tāmaki Makaurau

Te Mata Kairangahau Māori
Ko Ngāti Awa te iwi
Ko Kimiora Raerino tōku ingoa

School of Population Health
Te Whare Wānanga o Tāmaki Makaurau

Kaiwhakahaere o te Kaupapa Ahunga
Ko Ngāti Porou te iwi
Ko Panapa Ehau tōku ingoa

School of Population Health
Te Whare Wānanga o Tāmaki Makaurau

Marae Māra Kai

Nā te māra kai te whakamātau a oranga - From the garden wellbeing is tasted

E te rangatira, tēnā koe,

Ina matau o Te Whare Wānanga o Tāmaki Makaurau, otirā o School of Population Health, kei te tirotiro, kei te rangahau i ngā hua o te āta mahitahi, whakatipu māra kai mō ngā whānau, ngā hapū, ngā iwi me ngā hapori piritata ki ngā marae. Ngā māra kai ki runga ki ngā marae he tauira tino whakahirahira hei whakapuawai i ngā torotorohanga hauora inahoki ko ōna painga puta whānui mō te tinana, huinga tāngata, ngā tikanga o te iwi me te toiora o te taiao.

Engari tokoiti noa iho te mohio o te uhinga painga mō te hunga kuhu atu ki ngā hāpaitanga o te māra kai a-marae mō te whānau, mō te hapū, mō te iwi me te hapori anō hoki o te marae. Kei te pīrangi mātou ki te rangahau tauwhitiwhiti i te hunga ngaki māra kai i ngā marae ki te tatau i ngā āhuatanga totika ka puta mai hei oranga ngākau mai rā i ngā pūkenga mohio o ngā hapori marae kei Tāmaki Makaurau. Tā

mātou whāinga atu he hura ake i ngā hua tino mātāmua mō ngā kaihāpai, he tirotiro i pēhea te tōtika o ngā māra kai o te marae te hiki kia eke ai ki ēnei putanga, ka tātari ai e pēhea ai ēnei āhuatanga whakapai ake i te oranga o te Māori.

Te mātatau ki ngā hua whaipainga o te kuhu ki roto ki ngā mahi hapai māra kai o te marae e tuaritia ai etahi tino mohiotanga e pā ana ki te pua katoa ake o āhuatanga māra kai o te marae mō te whanau, te hapu, te iwi me te hapori. Te tino aro matawai o tēnei rangahau he ātā mohio he tāutu i ngā mea totika mō te hunga haapai i ngā mahi kai o te māra marae ka toha ai i ēnei Mohiotanga ki ētahi atu marae puta noa i Tāmaki Makaurau (kia Aotearoa whānui)

Ka puta tā mātou tono kia koe kia kuhu mai ki tēnei rangahau inara te whakaae anō māu e rua haora noa iho mōu anake kia wātea mō te uiui tauwhitiwhiti katahi ka hui atu hoki ki te hui rōpū arotahi te roanga o tēnei o ngā hui tataki te toru haora. Kei a koe anō te tikanga mēnā koe hiahia te kuhu mai ki tēnei uiui tauwhiti, ka taea noa iho e koe te kukume mai ia koe kia puta mai i ēnei nekenekehanga. Ka taea hoki e koe te kukume mai ki waho ngā marau kua tukua e koe tae noa ki tō whakaputanga mai, hei muri i te 30 rā mai i te wā i hoaturia te tuhinga tauwhitiwhiti. Mēnā ka kukume te marae ia ratou ki waho o te rangahau ka pera anō hoki te hunga i kuhu atu ki te rangahau.

Ka whakahaeretia ngā tauwhitihiti ka hopukina hokitia e tētahi Kairangahau Māori me tētahi kaihopu kupu e tino matatau anō ki ngā tikanga me te reo. Ka taea e koe te tono tētahi kaiuiui matatau ki te reo mēnā e hiahia ana koe ki te kawe i au uiui i roto i te reo Māori. Kei roto i ou ringa te rere o tēnei uiui tauwhitiwhiti otirā ko ngā take me te ia o ngā korero ka waihotia ki tōu ake ngakau taketakenga. Ka hopukina ēnei tauwhitiwhiti, a, ka whakamaua ki te kōpae. Ka tuhia ēnei kupu tauwhitiwhiti, ka noho araitia. Mēnā ka tikinatia tētahi ratonga hopu kupu ka tuhia ka noho araitia ēnei kupu ēnei korero. I te wā o tōu tauwhitiwhiti ka taea e koe te kati te whakatū i te hopu korero. Muri mai i te tauwhitiwhiti ka hoaturia he kape of ngā korero ka kohia hei pānui, hei whakatika, hei whakahoki mai kia mātau i roto i ngā rā 30. Koinei te wā mōu hei kukume mei ki waho he whakamārama rānei i ētahi pūrongo.

Ia marae kei roto i tēnei rangahau ka tohungia, ka whakahuainatia i roto i ngā ripoata rangahau. Ka rārangitia ngā ingoa o te hunga i kuhu ki te rangahau kei roto i ngā ripoata; Engari kō ngā mūrau me ngā whakairo ka puta mai ka utaina atu ki runga kē ki ngā rōpū ehara i te mea kotahi. Kei te hunga anō te tikanga mēnā ka hiahia a ia kia whakahuaina ake a ia i raro i tetahi ingoa whānui, inara He mema kai ngaki māra. Kei a koe anō te tikanga mēnā koe e hiahia kia noho huna tōu ingoa. Te katoa o ngā kupu korero ka kohia (tuhinga kōpae a-tuhituhi) ka maupātakatia ka rakaina i Te Whare Wānanga o Tāmaki Makaurau, mō te ono tau katahi ka whakakorehia.

Na te Kaunihera Rangahau Hauora tēnei rangahau i āwhina ki te moni, na te karati Rangahau Māori (11/623) Na te Komiti Tikanga Tangata o Te Whare Wānanga o Tāmaki Makaurau i hoatu te whakaaetanga tikanga.

Kō tāu tirohanga e pā ana ki te hua painga katoa inara mō te Māra kai a Marae e tino hiahiatia ana. **Ka tukua he koha kia rātou i uiui tauwhitiwhitihia ina he tohu koha he hua whenua anō hoki**

Te huanga pai mō tēnei kaupapa ka reretika i runga anō i te āta haerenga kōrero ngātahi i waenganui i ngā marae me te hunga e ngaki māra kai ana, inahoki ka whakahautia e mātou kia kuhu mai ki ngā aromatawai o ngā hua mai te rangahau me ngā whakaaturanga o ngā māra kai. Ngā marau ka puta mai i te rangahau ka tuaritia ki te hunga kei roto i tēnei rangahau. Kei roto anō hoki i tēnei kaupapa ahunga he tākutanga mō te Kairangahau mō Kimiora Raerino, kei runga anō hoki I tāu tono ka imēratia atu tera pea he rāpototanga o ngā kitenga o te rangahau otīa he kape a-hiko

Te Kupenga Hauora Māori School of Population Health Pēke Taumaiti 90219 Tāmaki Makaurau	School of Environment Pēke Taumaiti 92019 Tāmaki Makaurau

Mēnā he uiui tāu e pā ana ki ngā tikanga rangahau ka āhei koe ki te whakapā atu ki Te Heamana, Te Whare Wānanga o Tamaki Makaurau Komiti mō ngā Tikanga Tauwhiriwhiri o Te Tangata, Te Whare Wānanga o Tāmaki Makaurau, Te Tari o te (Vice Chancellor) Pēke Taumaiti 9201, Akarana. Waea 373 7599 hono 83711

I WHAKAAETIA E TE WHARE WĀNANGA O TĀMAKI MAKAURAU KOMITI MŌ NGĀ TIKANGA TAUWHIRIWHIRI O TE TANGATA I TE 23 O AKUHATA 2011 MŌ TE TORU TAU NAMA. HEI WHAKAPĀ 2011/392

Appendix C: Respondent Consent Form (Combined)

School of Population Health
THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Te Kupenga Hauora Māori
Cnr Morrin Road & Merton Road, St Johns
The University of Auckland
Private Bag 92019
Auckland, New Zealand
Telephone: 64 9 373 7599

Marae Food Gardens

Nā te māra kai te whakamātau a oranga - From the garden wellbeing is tasted

A University of Auckland Study of Health and Wellbeing through urban marae in Tāmaki Makaurau

Consent Form

This form will be held for a period of six years

- I have read and understood the Information Sheet
- I have had the opportunity to ask questions, and I am happy with the answers given to me.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time. I understand I can also withdraw any information I have given up to my withdrawal, until the completion of the study.
- I understand if my marae withdraws from this study, I will also be withdrawn from the study
- I wish the interview to be in te reo Māori

  YES / NO (please circle one)
- I understand that interviews will be recorded and transcribed(written up)
- I understand that the recording for the individual interviews can be stopped at any time, however, recording cannot be stopped for the focus group.
- I understand I have the option to leave the recorded focus group, should I decide not to answer the question.
- I understand that the recording of my interviews will be used for data analysis (to write up a report).
- I understand that I can withdraw any information I have given in my interviews up to 30 days after receiving the transcript (written copy) of my interview for review.
- I understand that I can only edit information from the focus group interviews, that is not relevant to the study, or data that provides identifiable information or names. I have 30 days after receiving the focus group transcript to review and edit data.
- I have had time to decide to take part
- I wish to be named in the research reports

  YES / NO (please circle one)
- I understand that if choose not to be named in the research reports, I will be identified as a Garden Project Member.
- I know who to contact if I have any questions about this study
- **I consent to being interviewed individually for approximately 2 hours and the focus group interview of 2-3 hours as part of the study**

Signature ..... **Date** / /

Full Name .....

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 23 AUGUST 2011 FOR 3 YEARS REFERENCE NUMBER 2011/392

School of Population Health

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Te Kupenga Hauora Māori
Cnr Morrin Road & Merton Road, St Johns
Telephone: 64 9 373 7599

The University of Auckland
Private Bag 92019
Auckland, New Zealand

Ngā Māra Kai o te Marae

Nā te māra kai te whakamātau a oranga - From the garden wellbeing is tasted

He rangahau nā Te Whare Wānanga o Tāmaki Makaurau mō te hauora a-oranga puta noa i ngā marae taone kei Tāmaki Mākaurau.

Kupu Whakaaetanga

Ka puritia tēnei pepa whakaae mō te roanga o te ono tau

- Kua pānuitia e au, kei te matatau ahau ki ngā kupu o te pepa marau
- Kua hōmaitia te wā hei uiui i ngā pātai, a, kua hoki mai te whakamārama ki tōku hiahia.
- Kei te mōhio ahau kei ahau anō te tikanga ki te kuhu atu ki tēnei rangahau (Kei tōku hiahia tonu) otirā kei ahau anō te mana ki te kukume i a au ki waho i tēnei rangahau. E mōhio hoki ana e au ka taea noaiho te kukume mai e au ngā marau me ngā korero kua hoatuhia e au mai te timatanga tae noa ki te mutunga o tēnei rangahau.
- Kei te mōhio ahau mēnā ka puta tōku marae i tēnei rangahau ka puta anō hoki ahau.
- E hiahia ana ahau kia kawea tōku whitiwhiti kōrero o tēnei rangahau ki roto i te reo Māori.

  AE/KAO (Porowhitatia kia kotahi)

- E mōhio ana ahau ēnei tauwhitiwhiti ka hopukina a-puoro, ana ka tuhia
- E mōhio hoki ana e au ngā hohopu puoro mō ia tauwhitiwhiti ka taea te kati i te wā e hiahiatia ana, engari, kahore e taea te aukati mō te rōpū tauwhiti arotahi.
- Kei te mōhio ahau kei ahau anō te tikanga ki te whakarere i te rōpū whitiwhiti arotahi i te wā e hiahia ana ahau, mēnā kua whakaaro iho ahau e kore au e whakahoki i te pātai.
- Kei te mōhio ahau ina ko te pūoro tauwhitiwhiti nā ku ka whakamahia ki roto i te kohinga tā taritari.
- Kei te mōhio ahau ka taea e au te kukume mai era tauwhitiwhiti kōrero hā ngai ki taku hiahia nā ku anō i hoatu otirā 30 ngā ra muri iho i te homaitanga o ngā tuhituhi o te rerenga tauwhitiwhiti hei tirotiro māku.
- E mōhio ana ahau ka taea noa iho e au te whakatika i era kōrero mai te rōpū arotahi kahore e pā ana ki te rangahau, inara i era kohinga kōrero e whakaputa ana, e whakahua ana rānei ētahi korero, ka taea kia nawai aua kupu inahoki te kitea kō wai ma ngā ingoa. 30 ngā rā mōku hei muri mai i te taunga mai o ngā tuhituhinga na te rōpū arotahi hei whakatikatika.
- Kua whakaae i te wā mōku ki te tohu mēnā ka kuhu, kaore rānei e kuhu ai ki roto i tēnei whakahaere.

- E hiahia ana ahau kia whakaingoatia ahau i roto i ēnei rīpoata rangahau.

  AE/KAO (Porowhitatia tētahi)

- Kei te mōhio ahau mēnā e kore ahau e hiahia kia whakaingoatia ahau i roto i ēnei rīpoata rangahau, ka whakahuatia ahau 'He Mema Kaupapa Māra'.

- Kei te mōhio ahau kō wai hei whakapā atu māku mēnā he pātai āku mō tēnei rangahau.

- **E whakaae ana ahau kia tauwhitiwhiti, ā, me kotahitia ahau mō te wā tata ki te rua haora ka kuhu atu ai ki te rōpū tauwhitiwhiti arotahi, e rua ki te toru haora pea inara hei wahanga mō te rangahau.**

Haina ..... **Rā** / /

Ō Ingoa katoa .....

WHAKAAETIA TE KOMITI O TE WHARE WĀNANGA O TĀMAKI MAKAURAU MŌ NGĀ ĀHUATANGA TIKANGA NA TE TANGATA I TE 23 AKUHATA 2011 MŌ TE TORU TAU TĀNGIA KI TE NAMA 2011/392

Appendix D: Parent Information Sheet

School of Population Health

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Te Kupenga Hauora Māori
Cnr Morrin Road & Merton Road, St Johns
Telephone: 64 9 373 7599

The University of Auckland
Private Bag 92019
Auckland, New Zealand

2012

INFORMATION SHEET

Principal Investigator:
Ko Ngāti Kahungunu te iwi
Ko Rhys Jones taku ingoa

Senior Lecturer
Te Kupenga Hauora Māori
School of Population Health
University of Auckland

Co-Investigator:
Ko Kāti Mamoe te iwi
Ko Brad Coombes taku ingoa

Senior Lecturer
School of Environment
University of Auckland

Co-Investigator:
Ko Australia te whenua
Ko Alex Macmillan taku ingoa

Senior Lecturer Environmental Health
School of Population Health
University of Auckland

Māori Research Fellow:
Ko Ngāti Awa te iwi
Ko Kimiora Raerino taku ingoa

School of Population Health
University of Auckland

Project Manager
Ko Ngāti Porou te iwi
Ko Panapa Ehau taku ingoa

School of Population Health
University of Auckland

Marae Food Gardens

Nā te māra kai te whakamātau a oranga - From the garden wellbeing is tasted

E te rangatira, tēnā koe,

At the University of Auckland, School of Population Health, we are exploring the benefits of active participation in marae food gardens for whānau, hapū, iwi and marae hapori. As your child has been involved with a marae garden we would like to interview your child to ask what his/her thoughts and experiences have been.

If your child agrees to participate in the research there will be a two hour single interview and one focus group meeting lasting approximately three hours. Your child's participation is voluntary, and your child can withdraw from the study at any time. Your child can also withdraw any information given up to the date of your child's withdrawal, up until 30 days after having been provided with the transcript of your child's interview. Marae, as research sites, also have the option to withdraw from this

study. If marae elect to withdraw from this study, then all associated marae participants will be withdrawn.

Interviews will be conducted and transcribed by a Māori researcher and transcriber who are familiar with tikanga and te reo. An interviewer who is fluent can be requested if it is preferred that the interviewed be in te reo. The direction the interview takes would be largely in your child's hands and the topics discussed would be those of most concern and interest to your child. Interviews will be recorded. These recordings will be transcribed, and content will be kept confidential. If a transcription service is used they will be bound by a strict confidentiality agreement. During your child's interview, the recording can be stopped at any time on your child's request. Following the interview, your child will be provided with a copy of the transcript for your child to read, edit and send back to us within 30 days. This is an opportunity to withdraw or clarify any information.

Food gardens on marae are an excellent example of a health promotion intervention that can have wide-ranging benefits for physical, social, cultural and environmental wellbeing. However little is known about the overall benefits of participation in marae gardens for whānau, hapū, iwi and the marae community itself. We would like to interview marae food garden participants to assess the positive outcomes of participation in marae food gardens to Māori wellbeing, based on experiences of marae communities in urban Tāmaki Makaurau. We aim to identify the most important wellbeing outcomes for participants, assess how well marae food gardens are helping to achieve these outcomes, and explore how particular aspects contribute to improving Māori wellbeing.

Understanding the beneficial outcomes of participation in urban marae food gardens will contribute valuable knowledge about the holistic outcomes of marae food gardens for whānau, hapū, iwi and hapori. The overall intention of this study is to understand and identify the positive impacts of active participant in marae food gardens and transfer this knowledge to other marae throughout Tāmaki Makaurau (and Aotearoa).

Each marae participating in this study will be identified and profiled in the research reports. A list of participants will be provided in reports; however specific comments and ideas will be ascribed to the group rather than particular individuals. Participants may request to be identified and named in the research reports or be identified in a generalised manner, e.g. Garden Project Member 1. Your child has the option to remain anonymous. All data (including digital files and written material) will be kept in secure storage at the University of Auckland for 6 years before being destroyed.

This research has been funded by the Health Research Council, Rangahau Hauora Māori grant (11/623). Ethical approval has been given by the Auckland University Human Ethics Committee.

Your childs perspectives on the overall benefits of active participation in marae food gardens would be greatly appreciated. **We will be providing koha for those interviewed in the form of a voucher and a plant when seasonally available.**

This project will largely benefit from ongoing consultation with each marae and participants, and we will encourage participation in the review of research results and the descriptions of the food gardens. The results of the research will be disseminated to all participants. This project also includes a doctorate for the Māori researcher Kimiora Raerino, upon request your child will be emailed either a summary of the research findings or an electronic copy of the entire thesis. Hui will be organised to discuss the findings of the research with each urban marae involved in the study.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 23 AUGUST 2011 FOR 3 YEARS REFERENCE NUMBER 2011/392

School of Population Health

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Te Kupenga Hauora Māori
Cnr Morrin Road & Merton Road, St Johns
Telephone: 64 9 373 7599

The University of Auckland
Private Bag 92019
Auckland, New Zealand

2012

RĀRANGI MARAU

Te Tino Kai-Wherawhera:
Ko Ngāti Kahungunu te iwi
Ko Rhys Jones tōku ingoa

Kaiako Matua
Te Kupenga Hauora Māori
School of Population Health
Te Whare Wānanga o Tāmaki Makaurau

Hoa Kai-Wherawhera:
Ko Kāti Mamoe te iwi
Ko Brad Coombes tōku ingoa

Kaiako Matua
School of Environment
Te Whare Wānanga o Tāmaki Makaurau

Hoa Kai-Wherawhera:
Ko Ahitereiria te whenua
Ko Alex Macmillan tōku ingoa

Kaiako Matua Hauora a Taiao
School of Population Health
Te Whare Wānanga o Tāmaki Makaurau

Te Mata Kairangahau Māori
Ko Ngāti Awa te iwi
Ko Kimiora Raerino tōku ingoa

School of Population Health
Te Whare Wānanga o Tāmaki Makaurau

Kaiwhakahaere o te Kaupapa Ahunga
Ko Ngāti Porou te iwi
Ko Panapa Ehau tōku ingoa

School of Population Health
Te Whare Wānanga o Tāmaki Makaurau

Marae Māra Kai

Nā te māra kai te whakamātau a oranga - From the garden wellbeing is tasted

E te rangatira, tēnā koe,

Ina matau o Te Whare Wānanga o Tāmaki Makaurau, otirā o School of Population Health, kei te tirotiro, kei te rangahau i ngā hua o te āta mahitahi, whakatipu māra kai mō ngā whānau, ngā hapū, ngā iwi me ngā hapori piritata ki ngā marae. Ngā māra kai ki runga ki ngā marae he tauira tino whakahirahira hei whakapuawai i ngā torotorohanga hauora inahoki ko ōna painga puta whānui mō te tinana, huinga tāngata, ngā tikanga o te iwi me te toiora o te taiao.

Engari tokoiti noa iho te mohio o te uhinga painga mō te hunga kuhu atu ki ngā hāpaitanga o te māra kai a-marae mō te whānau, mō te hapū, mō te iwi me te hapori anō hoki o te marae. Kei te pīrangi mātou ki te rangahau tauwhitiwhiti i te hunga ngaki māra kai i ngā marae ki te tatau i ngā āhuatanga totika ka puta mai hei oranga

ngākau mai rā i ngā pūkenga mohio o ngā hapori marae kei Tāmaki Makaurau. Tā mātou whāinga atu he hura ake i ngā hua tino mātāmua mō ngā kaihāpai, he tirotiro i pēhea te tōtika o ngā māra kai o te marae te hiki kia eke ai ki ēnei putanga, ka tātari ai e pēhea ai ēnei āhuatanga whakapai ake i te oranga o te Māori.

Te mātatau ki ngā hua whaipainga o te kuhu ki roto ki ngā mahi hapai māra kai o te marae e tuaritia ai etahi tino mohiotanga e pā ana ki te pua katoa ake o āhuatanga māra kai o te marae mō te whanau, te hapu, te iwi me te hapori. Te tino aro matawai o tēnei rangahau he ātā mohio he tāutu i ngā mea totika mō te hunga haapai i ngā mahi kai o te māra marae ka toha ai i ēnei Mohiotanga ki ētahi atu marae puta noa i Tāmaki Makaurau (kia Aotearoa whānui)

Ka puta tā mātou tono kia koe kia kuhu mai ki tēnei rangahau inara te whakaae anō māu e rua haora noa iho mōu anake kia wātea mō te uiui tauwhitiwhiti katahi ka hui atu hoki ki te hui rōpū arotahi te roanga o tēnei o ngā hui tataki te toru haora. Kei a koe anō te tikanga mēnā koe hiahia te kuhu mai ki tēnei uiui tauwhiti, ka taea noa iho e koe te kukume mai ia koe kia puta mai i ēnei nekenekehanga. Ka taea hoki e koe te kukume mai ki waho ngā marau kua tukua e koe tae noa ki tō whakaputanga mai, hei muri i te 30 rā mai i te wā i hoaturia te tuhinga tauwhitiwhiti. Mēnā ka kukume te marae ia ratou ki waho o te rangahau ka pera anō hoki te hunga i kuhu atu ki te rangahau.

Ka whakahaeretia ngā tauwhitihiti ka hopukina hokitia e tētahi Kairangahau Māori me tētahi kaihopu kupu e tino matatau anō ki ngā tikanga me te reo. Ka taea e koe te tono tētahi kaiuiui matatau ki te reo mēnā e hiahia ana koe ki te kawe i au uiui i roto i te reo Māori. Kei roto i ou ringa te rere o tēnei uiui tauwhitiwhiti otirā ko ngā take me te ia o ngā korero ka waihotia ki tōu ake ngakau taketakenga. Ka hopukina ēnei tauwhitiwhiti, a, ka whakamaua ki te kōpae. Ka tuhia ēnei kupu tauwhitiwhiti, ka noho araitia. Mēnā ka tikinatia tētahi ratonga hopu kupu ka tuhia ka noho araitia ēnei kupu ēnei korero. I te wā o tōu tauwhitiwhiti ka taea e koe te kati te whakatū i te hopu korero. Muri mai i te tauwhitiwhiti ka hoaturia he kape of ngā korero ka kohia hei pānui, hei whakatika, hei whakahoki mai kia mātau i roto i ngā rā 30. Koinei te wā mōu hei kukume mei ki waho he whakamārama rānei i ētahi pūrongo.

Ia marae kei roto i tēnei rangahau ka tohungia, ka whakahuainatia i roto i ngā ripoata rangahau. Ka rārangitia ngā ingoa o te hunga i kuhu ki te rangahau kei roto i ngā ripoata; Engari kō ngā mūrau me ngā whakairo ka puta mai ka utaina atu ki runga kē ki ngā rōpū ehara i te mea kotahi. Kei te hunga anō te tikanga mēnā ka hiahia a ia kia whakahuaina ake a ia i raro i tetahi ingoa whānui, inara He mema kai ngaki māra. Kei a koe anō te tikanga mēnā koe e hiahia kia noho huna tōu ingoa. Te katoa o ngā kupu korero ka kohia (tuhinga kōpae a-tuhituhi) ka maupātakatia ka rakaina i Te Whare Wānanga o Tāmaki Makaurau, mō te ono tau katahi ka whakakorehia.

Na te Kaunihera Rangahau Hauora tēnei rangahau i āwhina ki te moni, na te karati Rangahau Māori (11/623) Na te Komiti Tikanga Tangata o Te Whare Wānanga o Tāmaki Makaurau i hoatu te whakaaetanga tikanga.

Kō tāu tirohanga e pā ana ki te hua painga katoa inara mō te Māra kai a Marae e tino hiahiatia ana. **Ka tukua he koha kia rātou i uiui tauwhitiwhitihia ina he tohu koha he hua whenua anō hoki**

Te huanga pai mō tēnei kaupapa ka reretika i runga anō i te āta haerenga kōrero ngātahi i waenganui i ngā marae me te hunga e ngaki māra kai ana, inahoki ka whakahautia e mātou kia kuhu mai ki ngā aromatawai o ngā hua mai te rangahau me ngā whakaaturanga o ngā māra kai. Ngā marau ka puta mai i te rangahau ka tuaritia ki te hunga kei roto i tēnei rangahau. Kei roto anō hoki i tēnei kaupapa ahunga he tākutanga mō te Kairangahau mō Kimiora Raerino, kei runga anō hoki I tāu tono ka

(09) 373 7599 Ext 86278 Te Kupenga Hauora Māori School of Population Health Pēke Taumaiti 90219 Tāmaki Makaurau	(09) 373 7599 Ext 88455 School of Environment Pēke Taumaiti 92019 Tāmaki Makaurau

Mēnā he uiui tāu e pā ana ki ngā tikanga rangahau ka āhei koe ki te whakapā atu ki Te Heamana, Te Whare Wānanga o Tamaki Makaurau Komiti mō ngā Tikanga Tauwhiriwhiri o Te Tangata, Te Whare Wānanga o Tāmaki Makaurau, Te Tari o te (Vice Chancellor) Pēke Taumaiti 9201, Akarana. Waea 373 7599 hono 83711

I WHAKAAETIA E TE WHARE WĀNANGA O TĀMAKI MAKAURAU KOMITI MŌ NGĀ TIKANGA TAUWHIRIWHIRI O TE TANGATA I TE 23 O AKUHATA 2011 MŌ TE TORU TAU NAMA. HEI WHAKAPĀ 2011/392

Appendix E: Under 16 & Parent Consent Form (Combined)

School of Population Health
THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Te Kupenga Hauora Māori
Cnr Morrin Road & Merton Road, St Johns
The University of Auckland
Private Bag 92019
Auckland, New Zealand
Telephone: 64 9 373 7599

Marae Food Gardens

Nā te māra kai te whakamātau a oranga - From the garden wellbeing is tasted

A University of Auckland Study of Health and Wellbeing through urban marae in Tāmaki Makaurau

Consent Form

This form will be held for a period of six years

- I have read and understood the Information Sheet
- I have had the opportunity to ask questions, and I am happy with the answers given to me.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time. I understand I can also withdraw any information I have given up to my withdrawal, until the completion of the study.
- I understand if my marae withdraws from this study, I will also be withdrawn from the study
- I wish the interview to be in te reo Māori

  YES / NO (please circle one)
- I understand that interviews will be recorded and transcribed(written up)
- I understand that the recording for the individual interviews can be stopped at any time, however, recording cannot be stopped for the focus group.
- I understand I have the option to leave the recorded focus group, should I decide not to answer the question.
- I understand that the recording of my interviews will be used for data analysis (to write up a report).
- I understand that I can withdraw any information I have given in my interviews up to 30 days after receiving the transcript (written copy) of my interview for review.
- I understand that I can only edit information from the focus group interviews, that is not relevant to the study, or data that provides identifiable information or names. I have 30 days after receiving the focus group transcript to review and edit data.
- I have had time to decide to take part
- I wish to be named in the research reports

  YES / NO (please circle one)
- I understand that if choose not to be named in the research reports, I will be identified as a Garden Project Member.
- I know who to contact if I have any questions about this study
- **I consent to being interviewed individually for approximately 2 hours and the focus group interview of 2-3 hours as part of the study**

Rangatahi Name: ..... Signature .....Date / /

Parent Name: ..... Signature .....Date / /

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 23 AUGUST 2011 FOR 3 YEARS REFERENCE NUMBER 2011/392

School of Population Health

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Te Kupenga Hauora Māori
Cnr Morrin Road & Merton Road, St Johns
Telephone: 64 9 373 7599

The University of Auckland
Private Bag 92019
Auckland, New Zealand

Ngā Māra Kai o te Marae

Nā te māra kai te whakamātau a oranga - From the garden wellbeing is tasted

He rangahau nā Te Whare Wānanga o Tāmaki Makaurau mō te hauora a-oranga puta noa i ngā marae taone kei Tāmaki Mākaurau.

Kupu Whakaaetanga

Ka puritia tēnei pepa whakaae mō te roanga o te ono tau

- Kua pānuitia e au, kei te matatau ahau ki ngā kupu o te pepa marau
- Kua hōmaitia te wā hei uiui i ngā pātai, a, kua hoki mai te whakamārama ki tōku hiahia.
- Kei te mōhio ahau kei ahau anō te tikanga ki te kuhu atu ki tēnei rangahau (Kei tōku hiahia tonu) otirā kei ahau anō te mana ki te kukume i a au ki waho i tēnei rangahau. E mōhio hoki ana e au ka taea noaiho te kukume mai e au ngā marau me ngā korero kua hoatuhia e au mai te timatanga tae noa ki te mutunga o tēnei rangahau.
- Kei te mōhio ahau mēnā ka puta tōku marae i tēnei rangahau ka puta anō hoki ahau.
- E hiahia ana ahau kia kawea tōku whitiwhiti kōrero o tēnei rangahau ki roto i te reo Māori.

AE/KAO (Porowhitatia kia kotahi)

- E mōhio ana ahau ēnei tauwhitiwhiti ka hopukina a-puoro, ana ka tuhia
- E mōhio hoki ana e au ngā hohopu puoro mō ia tauwhitiwhiti ka taea te kati i te wā e hiahiatia ana, engari, kahore e taea te aukati mō te rōpū tauwhiti arotahi.
- Kei te mōhio ahau kei ahau anō te tikanga ki te whakarere i te rōpū whitiwhiti arotahi i te wā e hiahia ana ahau, mēnā kua whakaaro iho ahau e kore au e whakahoki i te pātai.
- Kei te mōhio ahau ina ko te pūoro tauwhitiwhiti nā ku ka whakamahia ki roto i te kohinga tā taritari.
- Kei te mōhio ahau ka taea e au te kukume mai era tauwhitiwhiti kōrero hā ngai ki taku hiahia nā ku anō i hoatu otirā 30 ngā ra muri iho i te homaitanga o ngā tuhituhi o te rerenga tauwhitiwhiti hei tirotiro māku.
- E mōhio ana ahau ka taea noa iho e au te whakatika i era kōrero mai te rōpū arotahi kahore e pā ana ki te rangahau, inara i era kohinga kōrero e whakaputa ana, e whakahua ana rānei ētahi korero, ka taea kia nawai aua kupu inahoki te kitea kō wai ma ngā ingoa. 30 ngā rā mōku hei muri mai i te taunga mai o ngā tuhituhinga na te rōpū arotahi hei whakatikatika.
- Kua whakaae i te wā mōku ki te tohu mēnā ka kuhu, kaore rānei e kuhu ai ki roto i tēnei whakahaere.

- E hiahia ana ahau kia whakaingoatia ahau i roto i ēnei rīpoata rangahau.

  AE/KAO (Porowhitatia tētahi)

- Kei te mōhio ahau mēnā e kore ahau e hiahia kia whakaingoatia ahau i roto i ēnei rīpoata rangahau, ka whakahuatia ahau 'He Mema Kaupapa Māra'.

- Kei te mōhio ahau kō wai hei whakapā atu māku mēnā he pātai āku mō tēnei rangahau.

- **E whakaae ana ahau kia tauwhitiwhiti, ā, me kotahitia ahau mō te wā tata ki te rua haora ka kuhu atu ai ki te rōpū tauwhitiwhiti arotahi, e rua ki te toru haora pea inara hei wahanga mō te rangahau.**

Ingoa Rangatahi: ..... Haina..... Rā / /

Inoga Matua: ..... Haina ..... Rā / /

WHAKAAETIA TE KOMITI O TE WHARE WĀNANGA O TĀMAKI MAKAURAU MŌ NGĀ ĀHUATANGA TIKANGA NA TE TANGATA I TE 23 AKUHATA 2011 MŌ TE TORU TAU TĀNGIA KI TE NAMA 2011/392

Appendix F: Photo Release Consent Form

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND
Te Whare Wānanga o Tāmaki Makaurau

MARAE FOOD GARDENS PROJECT
PHOTO RELEASE CONSENT FORM

SITUATIONAL PHOTOGRAPHS:

Photo date: _____ Number of photo's: _____

Photo location: _____

PERSON IN PHOTOGRAPH

Name: _____

Name: _____

Name: _____

(If more than one person per photo, please sign approval by your name)

I agree that the University may publish:

- Photographs of the marae and marae gardens (including buildings and grounds)
- my likeness (recorded by means of audio, video, film, photograph or such other format as may now or in the future exist or be discovered),
- (where necessary) my name and relevant information (but not publish my date of birth and contact details)

in any of The University of Auckland's Marae Food Gardens research material in any media (for example: website, print, cinema, video or such other media as may now or in the future exist or be discovered).

I agree that:

- copyright of all resulting images and other material is the property of The University of Auckland.
- The University of Auckland is under no obligation to provide electronic copies of the resulting images and other material.

AUTHORISING DETAILS

Signed: _____ Date: _____

Position: _____

Contact: _____

Thank you. Your participation is much appreciated.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 02 MARCH 2012 FOR 3 YEARS REFERENCE NUMBER 2011/392

4. Do not forget to fill in the 'approval wording' on the Participant Information Sheets and Consent Forms, giving the dates of approval and the reference number, before you send them out to your participants.

5. Send a copy of this approval letter to: Manager, Funding Processes, Research Office if you have obtained funding other than from UniServices. For a UniServices contract, send a copy of the approval letter to: Contract Manager, UniServices.

6. Please note that the Committee may from time to time conduct audits of approved projects to ensure that the research has been carried out according to the approval that was given.

Appendix H: Transcriber Confidentiality Agreement

School of Population Health

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Te Kupenga Hauora Māori
Cnr Morrin Road & Merton Road, St Johns
Telephone: 64 9 373 7599

The University of Auckland
Private Bag 92019
Auckland, New Zealand

MARAE FOOD GARDENS PROJECT
Confidentiality Agreement: Transcriber/Translator

I, _____, the *Research Assistant/Transcriber/Translator*, agree to:

1. Keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g., disks, tapes, transcripts) with anyone other that the *Researcher(s)*
2. Keep all research information in any form or format (e.g., disks, tapes, transcripts) secure while it is in my possession.
3. Return all research information in any form or format (e.g., disks, tapes, transcripts) to the *Researcher(s)* when I have completed the research tasks
4. After consulting with the *Researcher(s)*, erase or destroy all research information in any form or format regarding this research project that is not returnable to the *Researcher(s)* (e.g., information stored on computer hard drive).

Research Assistant/Transcriber/Translator

_____ _____ _____
(print name) (signature) (date)

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 23 AUGUST 2011 FOR 3 YEARS REFERENCE NUMBER 2011/392

References

Absolon, K. E. (2008). Kaandosswin, this is how We Come to Know! Indigenous Graduate Research in the Academy: Worldviews and Methodologies. (Doctor of Philosophy Doctorate), University of Toronto Canada. Retrieved from https://books.google.co.nz/books?id=-Y5Z_tf9cbIC

Adds, P., Hall, M., Higgins, R., & Higgins, T. R. (2011). Ask the posts of our house: using cultural spaces to encourage quality learning in higher education. Teaching in Higher Education, 16(5), 541-551.

Adelson, N. (2005). The Embodiment of Inequity: Health Disparities in Aboriginal Canada. Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique, 96, S45-S61.

Agustina, I., & Beilin, R. (2012). Community Gardens: Space for Interactions and Adaptations. Procedia - Social and Behavioral Sciences, 36(0), 439-448.

Ahern, J., Cerda, M., Lippman, S. A., Tardiff, K. J., Vlahov, D., & Galea, S. (2013). Navigating non-positivity in neighbourhood studies: an analysis of collective efficacy and violence. Journal of Epidemiology and Community Health, 67(2), 159-165. doi:10.1136/jech-2012-201317

Ahern, J., & Galea, S. (2011). Collective Efficacy and Major Depression in Urban Neighborhoods. American Journal of Epidemiology, 173(12), 1453-1462. doi:10.1093/aje/kwr030

Ahern, J., Galea, S., Hubbard, A., & Syme, S. L. (2009). Neighborhood smoking norms modify the relation between collective efficacy and smoking behavior. Drug and Alcohol Dependence, 100(1-2), 138-145. doi:10.1016/j.drugalcdep.2008.09.012

Ahn, H. S., Usher, E. L., Butz, A., & Bong, M. (2016). Cultural differences in the understanding of modelling and feedback as sources of self-efficacy information. British Journal of Educational Psychology, 86(1), 112-136. doi:10.1111/bjep.12093

Airhihenbuwa, C. O., Ford, C. L., & Iwelunmor, J. I. (2014). Why Culture Matters in Health Interventions: Lessons From HIV/AIDS Stigma and NCDs. Health Education & Behavior, 41(1), 78-84. doi:10.1177/1090198113487199

Akande, V. O., Hendriks, A. M., Ruiter, R. A., & Kremers, S. P. (2015). Determinants of dietary behavior and physical activity among Canadian Inuit: a systematic review. International Journal of Behavioral Nutrition and Physical Activity, 12(1), 84.

Al-Delaimy, W. K., & Webb, M. (2017). Community Gardens as Environmental Health Interventions: Benefits Versus Potential Risks. Current Environmental Health Reports, 4(2), 252-265. doi:10.1007/s40572-017-0133-4

Alaimo, K., Beavers, A. W., Crawford, C., Snyder, E. H., & Litt, J. S. (2016). Amplifying Health Through Community Gardens: A Framework for Advancing Multicomponent, Behaviorally Based Neighborhood Interventions. Current Environmental Health Reports, 3(3), 302-312. doi:10.1007/s40572-016-0105-0

Alaimo, K., Reischl, T. M., & Allen, J. O. (2010). Community gardening, neighborhood meetings, and social capital. Journal of Community Psychology, 38(4), 515-531.

Alegria, M., Atkins, M., Farmer, E., Slaton, E., & Stelk, W. (2010). One size does not fit all: taking diversity, culture and context seriously. Administration and Policy in Mental Health and Mental Health Services Research, 37(1-2), 48-60.

Alford, K. (2014). Economic value of Aboriginal community controlled health services. Canberra: National Aboriginal Community Controlled Health Organisation.

Alkon, A. H. (2013). Food Justice, Food Sovereignty and the Challenge of Neoliberalism. Paper presented at the Food Sovereignty: A Critical Dialogue, Yale University.

Alkon, A. H., & Mares, T. M. (2012). Food sovereignty in US food movements: radical visions and neoliberal constraints. Agriculture and Human Values, 29(3), 347-359. doi:10.1007/s10460-012-9356-z

Allen, J., Hopper, K., Wexler, L., Kral, M., Rasmus, S., & Nystad, K. (2014). Mapping resilience pathways of Indigenous youth in five circumpolar communities. Transcultural Psychiatry, 51(5), 601-631. doi:10.1177/1363461513497232

Allen, J., Mohatt, G. V., Markstrom, C. A., Byers, L., & Novins, D. K. (2012). “Oh No, We Are Just Getting to Know You”: The Relationship in Research With Children and Youth in Indigenous Communities. Child Development Perspectives, 6(1), 55-60. doi:10.1111/j.1750-8606.2011.00199.x

Allen, M. S., Jones, M. V., & Sheffield, D. (2009). Attribution, Emotion, and Collective Efficacy in Sports Teams. Group Dynamics-Theory Research and Practice, 13(3), 205-217. doi:10.1037/a0015149

Allen, P. (2010). Realizing justice in local food systems. Cambridge Journal of Regions, Economy and Society, 3(2), 295-308. doi:10.1093/cjres/rsq015

Althaus Ottman, M. M., Maantay, J. A., Grady, K., Cardoso, N., & da Fonte, N. N. (2010). Community Gardens: An Exploration of Urban Agriculture in the Bronx, New York City. Cities and the environment, 3(1), 20.

Anderson, H., & Kowal, E. (2012). Culture, History, and Health in an Australian Aboriginal Community: The Case of Utopia. Medical Anthropology, 31, 438-457. doi:10.1080/01459740.2011.636411

Anderson, I., Robson, B., Connolly, M., Al-Yaman, F., Bjertness, E., King, A., . . . Coimbra, C. E. (2016). Indigenous and tribal peoples' health (The Lancet–Lowitja Institute Global Collaboration): a population study. The Lancet, 388(10040), 131-157.

Anderson, I. P. S., & Whyte, J. D. (2008). Populations at Special Health Risk: Indigenous Populations. In H. Editor-in-Chief: Kris (Ed.), International Encyclopedia of Public Health (pp. 215-224). Oxford: Academic Press.

Aniza, I., & Norhayati, M. (2016). Barriers to health promotion for indigenous communities: Lessons for Malaysia. Malaysian Journal of Public Health Medicine, 16(1), 6-14.

Armstrong, D. (2000). A survey of community gardens in upstate New York: Implications for health promotion and community development. Health & Place, 6, 319-327.

Ashford, S., Edmunds, J., & French, D. P. (2010). What is the best way to change self-efficacy to promote lifestyle and recreational physical activity? A systematic review with meta-analysis. British Journal of Health Psychology, 15(2), 265-288.
Auger, M., Howell, T., & Gomes, T. (2016). Moving toward holistic wellness, empowerment and self-determination for Indigenous peoples in Canada: Can traditional Indigenous health care practices increase ownership over health and health care decisions? Canadian Journal of Public Health, 107(4/5), E393.
Auger, M. D. (2016). Cultural Continuity as a Determinant of Indigenous Peoples' Health: A Metasynthesis of Qualitative Research in Canada and the United States. International Indigenous Policy Journal, 7(4).
Australian Indigenous Health InfoNet. (2015). Overview of Aboriginal and Torres Strait Islander health status 2015. In. Retrieved from http://www.healthinfonet.ecu.edu.au/health-facts/overviews
Aveling, N. (2013). 'Don't talk about what you don't know': on (not) conducting research with/in Indigenous contexts. Critical Studies in Education, 54(2), 203-214. doi:10.1080/17508487.2012.724021
Axelsson, P., Kukutai, T., & Kippen, R. (2016). The field of Indigenous health and the role of colonisation and history. Journal of Population Research, 1-7. doi:10.1007/s12546-016-9163-2
Ayo, N. (2012). Understanding health promotion in a neoliberal climate and the making of health conscious citizens. Critical Public Health, 22(1), 99-105.
Baba, J. T., Brolan, C. E., & Hill, P. S. (2014). Aboriginal medical services cure more than illness: a qualitative study of how Indigenous services address the health impacts of discrimination in Brisbane communities. International Journal for Equity in Health, 13(1), 56.
Ball, K. (2015). Traversing myths and mountains: addressing socioeconomic inequities in the promotion of nutrition and physical activity behaviours. International Journal of Behavioral Nutrition and Physical Activity, 12(1), 142. doi:10.1186/s12966-015-0303-4
Bandura, A. (1977). Self-efficacy - Toward a unifying theory of behavioral change. Psychological Review, 84(2), 191-215. doi:10.1037//0033-295x.84.2.191
Bandura, A. (1985). Model of Causality in Social Learning Theory. In M. J. Mahoney & A. Freeman (Eds.), Cognition and Psychotherapy (pp. 81-99). Boston, MA: Springer US.
Bandura, A. (1986). Social Foundations of Thought and Action: A Social Cognitive Theory. Englewood Cliffs, NJ: Prentice Hall.
Bandura, A. (1989). Human agency in social cognitive theory. American Psychologist, 44(9), 1175.
Bandura, A. (1997). Self-efficacy: the exercise of control. New York: WH Freeman.
Bandura, A. (2000a). Exercise of Human Agency Through Collective Efficacy. Current Directions in Psychological Science, 9(3), 75-78. doi:10.1111/1467-8721.00064
Bandura, A. (2000b). Self-Efficacy: The Foundation of Agency. In W. J. Perrig & A. Grob (Eds.), Control of human behavior, mental processes, and consciousness: Essays in honor of the 60th birthday of August Flammer (pp. 16). New Jersey, USA: Lawerence Erlbaum Associates Inc. Publishers.
Bandura, A. (2001). Social cognitive theory: An agentic perspective. Annual review of psychology, 52(1), 1-26.
Bandura, A. (2002). Social Cognitive Theory in Cultural Context. Applied Psychology: An International Review, 51(2), 269.
Bandura, A. (2004). Health Promotion by Social Cognitive Means. Health Education & Behavior, 31(2), 143-164. doi:10.1177/1090198104263660
Bandura, A. (2007). Self-efficacy in health functioning. In S. Ayers, A. Baum, & c. McManus (Eds.), Cambridge Handbook of Psychology, Health and Medicine: Cambridge University Press.
Bandura, A. (2010). Self-Efficacy. In The Corsini Encyclopedia of Psychology: John Wiley & Sons, Inc.
Bandura, A. (2011). The social and policy impact of Social Cognitive Theory. In M. Mark, S. Donaldson, & B. Campbell (Eds.), Social psychology and evaluation (pp. 33-70). New York: The Guilford Press.
Bandura, A. (2012). On the Functional Properties of Perceived Self-Efficacy Revisited. Journal of Management, 38(1), 9-44. doi:10.1177/0149206311410606
Bandura, A., Caprara, G. V., Barbaranelli, C., Regalia, C., & Scabini, E. (2011). Impact of Family Efficacy Beliefs on Quality of Family Functioning and Satisfaction with Family Life. Applied Psychology-an International Review-Psychologie Appliquee-Revue Internationale, 60(3), 421-448. doi:10.1111/j.1464-0597.2010.00442.x
Bandura, A., & Jourden, F. J. (1991). Self-Regulatory Mechanisms Governing the Impact of Social Comparison on Complex Decision Making. Journal of Personality and Social Psychology, 60(6), 941-951.
Bandura, A., & Locke, E. A. (2003). Negative self-efficacy and goal effects revisited. Journal of Applied Psychology, 88(1), 87-99. doi:10.1037/0021-9010.88.1.87
Bandura, A., & Walters, R. (1963). Social learning and personality development New York: Holt, Reinhart & Wilson.
Barber, F. (2013). Effects of Social Support on Physical Activity, Self-Efficacy, and Quality of Life in Adult Cancer Survivors and Their Caregivers Oncology Nursing Forum, 40(5), 481-489.
Barcham, M. (2004). The politics of Māori mobility. In J. Taylor & B. Bell (Eds.), Population Mobility and Indigenous Peoples in Australasia and North America (pp. 165-183). London: Routledge.
Barker, C., Crengle, S., Bramley, D., Bartholomew, K., Bolton, P., Walsh, M., & Wignall, J. (2016). Pathways to ambulatory sensitive hospitalisations for Māori in the Auckland and Waitemata regions. The New Zealand Medical Journal, 129(1444), 15.
Barlow, J. (2013). Self-efficacy in the context of rehabilitation. International Encyclopedia of Rehabilitation. Retrieved from cirrie.buffalo.edu/encyclopedia/en/article/35/
Barnett, L., & Kendall, E. (2011). Culturally appropriate methods for enhancing the participation of Aboriginal Australians in health-promoting programs. Health Promotion Journal of Australia, 22(1), 27-32.
Barron, J. (2016). Community gardening: cultivating subjectivities, space, and justice. Local Environment, 1-17. doi:10.1080/13549839.2016.1169518

Bassett, D., Tsosie, U., & Nannauck, S. (2012). Our culture is medicine": Perspectives of native healers on posttrauma recovery among American Indian and Alaska Native patients. The Permanente Journal, 16(1), 19-27.
Basu, A., Dillon, P. J., & Romero-Daza, N. (2016). Understanding Culture and Its Influence on HIV/AIDS-Related Communication Among Minority Men Who Have Sex With Men. Health Communication, 31(11), 1367-1374. doi:10.1080/10410236.2015.1072884
Bauer, G. F. (2017). The Application of Salutogenesis in Everyday Settings. In M. B. Mittelmark, S. Sagy, M. Eriksson, G. F. Bauer, J. M. Pelikan, B. Lindström, & G. A. Espnes (Eds.), The Handbook of Salutogenesis (pp. 153-158). Cham: Springer International Publishing.
Baum, F., & Fisher, M. (2014). Why behavioural health promotion endures despite its failure to reduce health inequities. Sociology of health & illness, 36(2), 213-225.
Baum, F., & M Sanders, D. (2011). Ottawa 25 years on: A more radical agenda for health equity is still required (Vol. 26 Suppl 2).
Becker, M., Vignoles, V. L., Owe, E., Brown, R., Smith, P. B., Easterbrook, M., . . . Yamakoglu, N. (2012). Culture and the Distinctiveness Motive: Constructing Identity in Individualistic and Collectivistic Contexts. Journal of Personality and Social Psychology, 102(4), 833-855. doi:10.1037/a0026853
Beckie, M. A., Kennedy, E. H., & Wittman, H. (2012). Scaling up alternative food networks: farmers' markets and the role of clustering in western Canada. Agriculture and Human Values, 29(3), 333-345. doi:http://dx.doi.org/10.1007/s10460-012-9359-9
Belgrave, M. (2014). Beyond the Treaty of Waitangi: Māori Tribal Aspirations in an Era of Reform, 1984–2014. The Journal of Pacific History, 49(2), 193-213. doi:10.1080/00223344.2014.898232
Bell, K., Couzos, S., Daniels, J., Hunter, P., Mayers, N., & Murray, R. (2000). Aboriginal community controlled health services. General practice in Australia, 2000, 74-103.
Bellows, A. C., Alcaraz, G., & Vivar, T. (2010). Gardening as Tool to Foster Health and Cultural Identity in the Context of International Migration: Attitudes and Constraints in a Female Population. In G. P. Gianquinto & F. Orsini (Eds.), Ii International Conference on Landscape and Urban Horticulture (Vol. 881, pp. 785-792).
Bennett, A. J. T. P. K. (2007). Marae: A whakapapa of the Maori marae. (Doctor of Philosophy Doctoral), University of Canterbury, Christchurch.
Berezin, M., & Lamont, M. (2016). Mutuality, mobilization, and messaging for health promotion: Toward collective cultural change. Social Science & Medicine, 165, 201-205. doi:http://dx.doi.org/10.1016/j.socscimed.2016.07.040
Berg, M., Coman, E., & Schensul, J. J. (2009). Youth Action Research for Prevention: A Multi-level Intervention Designed to Increase Efficacy and Empowerment Among Urban Youth. American Journal of Community Psychology, 43(3-4), 345-359. doi:10.1007/s10464-009-9231-2
Berry, H. L., Butler, J. R., Burgess, C. P., King, U. G., Tsey, K., Cadet-James, Y. L., . . . Raphael, B. (2010). Mind, body, spirit: co-benefits for mental health from climate change adaptation and caring for country in remote Aboriginal Australian communities. New South Wales Public Health Bulletin, 21(6), 139-145.
Berry, N. S., Murphy, J., & Coser, L. (2014). Empowerment in the field of health promotion: Recognizing challenges in working toward equity. Global Health Promotion, 21(4), 35-43. doi:10.1177/1757975914528725
Berry, S. L., Crowe, T. P., Deane, F. P., Billingham, M., & Bhagerutty, Y. (2012). Growth and Empowerment for Indigenous Australians in Substance Abuse Treatment. International Journal of Mental Health and Addiction, 10(6), 970-983. doi:10.1007/s11469-012-9393-2
Berryman, M., SooHoo, S., Orange, C. A., & Nevin, A. (2013). Culturally Responsive Methodologies From the Margins. Culturally Responsive Methodologies.
Bersamin, A., Wolsko, C., Luick, B. R., Boyer, B. B., Lardon, C., Hopkins, S. E., . . . Zidenberg-Cherr, S. (2014). Enculturation, perceived stress, and physical activity: implications for metabolic risk among the Yup'ik - The Center for Alaska Native Health Research Study. Ethnicity & Health, 19(3), 255-269. doi:10.1080/13557858.2012.758691
Beverly, E. A., & Wray, L. A. (2010). The role of collective efficacy in exercise adherence: a qualitative study of spousal support and Type 2 diabetes management. Health Education Research, 25(2), 211-223. doi:10.1093/her/cyn032
Beynon, D. (2013). The contemporary Iban longhouse: The sustenance and applicability of a socio-spatial culture. International journal of social sustainability in economic, social, and cultural context, 9(1), 87-99.
Biddle, N., & Swee, H. (2012). The Relationship between Wellbeing and Indigenous Land, Language and Culture in Australia. Australian Geographer, 43(3), 215-232. doi:10.1080/00049182.2012.706201
Big-Canoe, K., & Richmond, C. A. M. (2014). Anishinabe youth perceptions about community health: Toward environmental repossession. Health & Place, 26, 127-135. doi:http://dx.doi.org/10.1016/j.healthplace.2013.12.013
Biglan, A. (1987). A behavior-analytic critique of Bandura's self-efficacy theory. The Behavior Analyst, 10(1), 1-15.
Bignante, E. (2015). Therapeutic landscapes of traditional healing: building spaces of well-being with the traditional healer in St. Louis, Senegal. Social & Cultural Geography, 16(6), 698-713. doi:10.1080/14649365.2015.1009852
Birky, J., & Strom, E. (2013). Urban perennials: How diversification has created a sustainable community garden movement in the United States. Urban Geography, 34(8), 1193-1216.
Black, A. P., Vally, H., Morris, P. S., Daniel, M., Esterman, A. J., Smith, F. E., & O'Dea, K. (2013). Health outcomes of a subsidised fruit and vegetable program for Aboriginal children in northern New South Wales. Med J Aust, 199(1), 46-50.

Bloch, P., Toft, U., Reinbach, H. C., Clausen, L. T., Mikkelsen, B. E., Poulsen, K., & Jensen, B. B. (2014). Revitalizing the setting approach–supersettings for sustainable impact in community health promotion. International Journal of Behavioral Nutrition and Physical Activity, 11(1), 118.
Block, D. R., Chavez, N., Allen, E., & Ramirez, D. (2012). Food sovereignty, urban food access, and food activism: contemplating the connections through examples from Chicago. Agriculture and Human Values, 29(2), 203-215. doi:10.1007/s10460-011-9336-8
Bombay, A., Matheson, K., & Anisman, H. (2010). Decomposing identity: differential relationships between several aspects of ethnic identity and the negative effects of perceived discrimination among First Nations adults in Canada. Cultural Diversity & Ethnic Minority Psychology, 16(4), 507-516.
Bond, C., Brough, M., Spurling, G., & Hayman, N. (2012). 'It had to be my choice' Indigenous smoking cessation and negotiations of risk, resistance and resilience. Health Risk & Society, 14(6), 565-581. doi:10.1080/13698575.2012.701274
Boreham, J. (2013). Dye spill reaches Manukau Harbour. Manukau Courier. Retrieved from http://www.stuff.co.nz/auckland/local-news/manukau-courier/8868407/Dye-spill-reaches-Manukau-Harbour
Borgen, F. H. (2005). Advancing Social Justice in Vocational Theory, Research, and Practice. The Counseling Psychologist, 33(2), 197-206. doi:10.1177/0011000004272722
Boulton, A., Gifford, H., Kauika, A., & Parata, K. (2011). Māori Health Promotion - Challenges for best practice. AlterNatives: An international journal of indigenous peoples, 7(1).
Boulton, A., & Gifford, H. H. (2014). Whanau Ora; He whakaaro a whanau: Maori family views of family wellbeing. International Indigenous Policy Journal, 5(1).
Boulton, A., Tamehana, J., & Brannelly, T. (2013). Whanau-centred Health and Social Service Delivery in New Zealand. MAI Journal, 2(1), 18-32.
Boulton, M. J. (2014). Teachers' Self-Efficacy, Perceived Effectiveness Beliefs, and Reported Use of Cognitive-Behavioral Approaches to Bullying Among Pupils: Effects of in-Service Training With the I DECIDE Program. Behavior Therapy, 45(3), 328-343.
Brand, E., Bond, C., & Shannon, C. (2016). Indigenous in the city: Urban indigenous populations in local and global contexts. Australia: UQ Poche Centre. The University of Queensland.
Brannan, D., Biswas-Diener, R., Mohr, C. D., Mortazavi, S., & Stein, N. (2013). Friends and family: A cross-cultural investigation of social support and subjective well-being among college students. Journal of Positive Psychology, 8(1), 65-75. doi:10.1080/17439760.2012.743573
Braunack-Mayer, A., & Louise, J. (2008). The ethics of Community Empowerment: tensions in health promotion theory and practice. Promotion & education, 15(3), 5-8.
Brewster, L. (2014). The public library as therapeutic landscape: A qualitative case study. Health & Place, 26, 94-99. doi:10.1016/j.healthplace.2013.12.015
Briones, E., Tabernero, C., Tramontano, C., Caprara, G. V., & Arenas, A. (2009). Development of a cultural self-efficacy scale for adolescents (CSES-A). International Journal of Intercultural Relations, 33(4), 301-312. doi:10.1016/j.ijintrel.2009.03.006
Brown, B. B., Altman, I., & Werner, C. M. (2012). Place Attachment. In J. S. Editor-in-Chief: Susan (Ed.), International Encyclopedia of Housing and Home (pp. 183-188). San Diego: Elsevier.
Brown, H. J., McPherson, G., Peterson, R., Newman, V., & Cranmer, B. (2012). Our land, our language: Connecting dispossession and health equity in an indigenous context. Canadian Journal of Nursing Research, 44(2), 44-63.
Brown, J. R. (2012). Spaces for developing sociocultural capital: a case study of community gardens in an Agrarian community. (Masters), North Dakota State University, North Dakota.
Brown, R. (2010). Organisational prerequisites to fund, implement and sustain Maori health promotion in a primary care setting. (Masters of Health Science), AUT University, Retrieved from http://aut.researchgateway.ac.nz/bitstream/handle/10292/938/BrownR.pdf?sequence=3
Browne, A. J., Varcoe, C., Lavoie, J., Smye, V., Wong, S. T., Krause, M., . . . Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. Bmc Health Services Research, 16(1), 544.
Browne, J., Laurence, S., & Thorpe, S. (2009). Acting on food insecurity in urban Aboriginal and Torres Strait Islander communities. Policy and practice interventions to improve local access and supply of nutritious food.
Browne-Yung, K., Ziersch, A., Baum, F., & Gallaher, G. (2013). Aboriginal Australians' experience of social capital and its relevance to health and wellbeing in urban settings. Social Science & Medicine, 97, 20-28. doi:10.1016/j.socscimed.2013.08.002
Browning, C. R., & Cagney, K. A. (2002). Neighborhood structural disadvantage, collective efficacy, and self-rated physical health in an urban setting. Journal of Health and Social Behavior, 43(4), 383-399. doi:10.2307/3090233
Browning, C. R., & Soller, B. (2014). Moving Beyond Neighborhood: Activity Spaces and Ecological Networks As Contexts for Youth Development. Cityscape (Washington, D.C.), 16(1), 165-196.
Burke, N. J., Bird, J. A., Clark, M. A., Rakowski, W., Guerra, C., Barker, J. C., & Pasick, R. J. (2009). Social and cultural meanings of self-efficacy. Health education & behavior : the official publication of the Society for Public Health Education, 36(5 Suppl), 111S-128S.
Burke, N. J., Joseph, G., Pasick, R. J., & Barker, J. C. (2009). Theorizing Social Context: Rethinking Behavioral Theory. Health Education & Behavior, 36(5 suppl), 55S-70S. doi:10.1177/1090198109335338
Burrage, R. L., Gone, J. P., & Momper, S. L. (2016). Urban American Indian Community Perspectives on Resources and Challenges for Youth Suicide Prevention. American Journal of Community Psychology, 58(1-2), 136-149. doi:10.1002/ajcp.12080

Cain, D., Pitpitan, E. V., Eaton, L., Carey, K. B., Carey, M. P., Mehlomakulu, V., . . . Kalichman, S. C. (2013). Collective efficacy and HIV prevention in south african townships. Journal of Community Health, 38(5), 885-893.
Calabria, B., Clifford, A., Rose, M., & Shakeshaft, A. P. (2014). Tailoring a family-based alcohol intervention for Aboriginal Australians, and the experiences and perceptions of health care providers trained in its delivery. Bmc Public Health, 14(1), 322.
Calabria, B., Clifford, A., Shakeshaft, A., Allan, J., Bliss, D., & Doran, C. (2013). The acceptability to Aboriginal Australians of a family-based intervention to reduce alcohol-related harms. Drug and Alcohol Review, 32(3), 328-332. doi:10.1111/j.1465-3362.2012.00525.x
Came, H., McCreanor, T., Doole, C., & Rawson, E. (2016). The New Zealand Health Strategy 2016: whither health equity? The New Zealand Medical Journal, 129(1447), 72.
Capstick, S., Norris, P., Sopoaga, F., & Tobata, W. (2009). Relationships between health and culture in Polynesia – A review. Social Science & Medicine, 68(7), 1341-1348. doi:10.1016/j.socscimed.2009.01.002
Cardinal, N. (2006). The exclusive city: Identifying, measuring, and drawing attention to Aboriginal and Indigenous experiences in an urban context. Cities, 23(3), 217-228. doi:10.1016/j.cities.2006.03.005
Carney, P., Hamada, J., Rdesinski, R., Sprager, L., Nichols, K., Liu, B., . . . Shannon, J. (2012). Impact of a Community Gardening Project on Vegetable Intake, Food Security and Family Relationships: A Community-based Participatory Research Study. Journal of Community Health, 37(4), 874-881. doi:10.1007/s10900-011-9522-z
Carroll, J. M., Rosson, M. B., & Zhou, J. (2005). Collective efficacy as a measure of community. Paper presented at the Proceedings of the SIGCHI Conference on Human Factors in Computing Systems, Portland, Oregon, USA.
Carson, K. V., Brinn, M. P., Peters, M., Veale, A., Esterman, A. J., & Smith, B. J. (2012). Interventions for smoking cessation in Indigenous populations. Cochrane Database of Systematic Reviews(1).
Castro, F. G., Barrera, M. J., & Holleran Steiker, L. K. (2010). Issues and Challenges in the Design of Culturally Adapted Evidence-Based Interventions. Annual review of clinical psychology, 6(1), 213-239. doi:10.1146/annurev-clinpsy-033109-132032
Catford, J. (2009). Advancing the 'science of delivery' of health promotion: not just the 'science of discovery'. Health Promotion International, 24(1), 1-5. doi:10.1093/heapro/dap003
Catford, J. (2011). Ottawa 1986: back to the future. Health Promotion International, 26(suppl 2), ii163-ii167. doi:10.1093/heapro/dar081
Certomà, C. (2015). Critical Urban Gardening. In M. Pimbert, R. Schidelar, & H. Hanna Schösler (Eds.), Think global, eat local: exploring foodways (pp. 13-17). Munich: RCC Perspective.
Certomà, C., & Tornaghi, C. (2015). Political gardening. Transforming cities and political agency. Local Environment, 20(10), 1123-1131. doi:10.1080/13549839.2015.1053724
Chan, J., Pennisi, L., & Francis, C. A. (2016). Social-Ecological Refuges: Reconnecting In Community Gardens In Lincoln, Nebraska. Journal of Ethnobiology, 36(4), 842-860. doi:10.2993/0278-0771-36.4.842
Chan, M. Y., Ip, W. Y., & Choi, K. C. (2016). The effect of a self-efficacy-based educational programme on maternal breast feeding self-efficacy, breast feeding duration and exclusive breast feeding rates: A longitudinal study. Midwifery, 36, 92-98. doi:http://dx.doi.org/10.1016/j.midw.2016.03.003
Chant, L. (2011). Whanau Ora: Hauora Māori models for kotahitanga/ co-operative co-existence with non- Māori. AlterNative: An International Journal of Indigenous Peoples, 7(2).
Chant, L. (2013). Hauora Kotahitanga - Maori health experiences as models for co-operative co-existence between indigenous and non-indigenous peoples. (Doctor of Philosophy), The University of Auckland, New Zealand.
Chilisa, B. (2012). Indigenous Research Methodologies. Los Angeles: SAGE Publications
Christensen, J. (2013). 'Our home, our way of life': spiritual homelessness and the sociocultural dimensions of Indigenous homelessness in the Northwest Territories (NWT), Canada. Social & Cultural Geography, 14(7), 804-828. doi:10.1080/14649365.2013.822089
Cidro, J., Adekunle, B., Peters, E., & Martens, T. (2015). Beyond Food Security: Understanding Access to Cultural Food for Urban Indigenous People in Winnipeg as Indigenous Food Sovereignty. Canadian Journal of Urban Research, 24(1), 24-43.
Cidro, J., Martens, T., & Guilbault, L. (2016). Traditional Indigenous Food Upskilling as a Pathway to Urban Indigenous Food Sovereignty. In F. Deer & T. Falkenberg (Eds.), INDIGENOUS PERSPECTIVES ON EDUCATION FOR WELL-BEING IN CANADA (pp. 41). Canada: Education for Sustainable Well-Being Press.
Cidro, J., Zahayko, L., Lawrence, H., McGregor, M., & McKay, K. (2014). Traditional and cultural approaches to childrearing: preventing early childhood caries in Norway House Cree Nation, Manitoba. Rural and remote health, 14(2968).
Clark, N. M., & Zimmerman, B. J. (2014). A Social Cognitive View of Self-Regulated Learning About Health. Health Education & Behavior, 41(5), 485-491. doi:10.1177/1090198114547512
Cohen, D. A., Finch, B. K., Bower, A., & Sastry, N. (2006). Collective efficacy and obesity: The potential influence of social factors on health. Social Science & Medicine, 62(3), 769-778. doi:10.1016/j.socscimed.2005.06.033
Cohen, D. A., Inagami, S., & Finch, B. (2008). The built environment and collective efficacy. Health & Place, 14(2), 198-208. doi:10.1016/j.healthplace.2007.06.001
Cohen, N. (2017). Closing the gap in diabetes: how is it going to be achieved? Endocrinology Today, 6(2), 31-33.
Colquhoun, S., & Dockery, A. M. (2012). The link between Indigenous culture and wellbeing: Qualitative evidence for Australian Aboriginal peoples: Centre for Labour Market Research Perth.

Companion, M. (2013). Obesogenic Cultural Drift and Nutritional Transition: Identifying Barriers to Healthier Food Consumption in Urban Native American Populations. Journal of Applied Social Science, 7(1), 80-94.
Comstock, N., Miriam Dickinson, L., Marshall, J. A., Soobader, M.-J., Turbin, M. S., Buchenau, M., & Litt, J. S. (2010). Neighborhood attachment and its correlates: Exploring neighborhood conditions, collective efficacy, and gardening. Journal of Environmental Psychology, 30(4), 435-442. doi:http://dx.doi.org/10.1016/j.jenvp.2010.05.001
Conigrave, K., Freeman, B., Caroll, T., Simpson, L., Lee, K. S. K., Wade, V., . . . Freeburn, B. (2012). The Alcohol Awareness project: community education and brief intervention in an urban Aboriginal setting. Health Promotion Journal of Australia, 23(3), 219-225.
Conradson, D. (2005). Landscape, care and the relational self: Therapeutic encounters in rural England. Health & Place, 11(4), 337-348. doi:10.1016/j.healthplace.2005.02.004
Cooper, E. (2012). Mokopuna Rising: Intervention in Whānau Violence. (Doctor of Philosophy in Psychology Doctorate), The University of Auckland, Te Whare Wānanga o Tāmaki Makaurau, New Zealand.
Coplen, A. K. (2013). Weighing in: obesity, food justice, and the limits of capitalism. Agriculture and Human Values, 30(3), 485-486. doi:10.1007/s10460-013-9455-5
Corntassel, J. (2012). Re-envisioning resurgence: Indigenous pathways to decolonization and sustainable self-determination. Decolonization: Indigeneity, Education & Society, 1(1).
Corrigan, M. P. (2011). Growing what you eat: Developing community gardens in Baltimore, Maryland. Applied Geography, 31(4), 1232-1241.
Corrigan, P. W. (1990). Theoretical weakness in behavior theory is no more than statistical variance: A response to Christina Lee. Journal of Behavior Therapy and Experimental Psychiatry, 21(2), 141-142. doi:10.1016/0005-7916(90)90019-H
Cram, F. (2001). Rangahau Maori : tona tika, tona pono : the validity and integrity of Māori research. In M. Tolich (Ed.), Research ethics in Aotearoa New Zealand : concepts, practice, critique. (pp. 35-52). Auckland: Longman.
Cram, F. (2010). Evaluation Framework - Maara Kai. Part 3 Programme Description & Expanded Intervention Logics - DRAFT. Auckland.
Cram, F., Hawke, R., Hawke, S., Huriwai, T. M., Mataki, T., Milne, M., . . . Tuuta, C. (2004). A research ethic for studying Maori and iwi provider success. Social Policy Journal of New Zealand(23), 141+.
Cunningham, C. (2000). A framework for addressing Maori knowledge in research, science and technology. Pacific health dialog, 7(1), 62-69.
Cunradi, C. B. (2010). Neighborhoods, Alcohol Outlets and Intimate Partner Violence: Addressing Research Gaps in Explanatory Mechanisms. International Journal of Environmental Research and Public Health, 7(3), 799.
D'Angelo, M. E. S., Pelletier, L. G., Reid, R. D., & Huta, V. (2014). The roles of self-efficacy and motivation in the prediction of short- and long-term adherence to exercise among patients with coronary heart disease. Health Psychology, 33(11), 1344-1353. doi:10.1037/hea0000094
Dana-Sacco, G. (2010). The Indigenous researcher as individual and collective: Building a research practice ethic within the context of Indigenous languages. The American Indian Quarterly, 34(1), 61-82.
Davidson, P. M., Jiwa, M., Digiacomo, M. L., McGrath, S. J., Newton, P. J., Durey, A. J., . . . Thompson, S. C. (2013). The experience of lung cancer in Aboriginal and Torres Strait Islander peoples and what it means for policy, service planning and delivery. Australian health review : a publication of the Australian Hospital Association, 37(1), 70-78. doi:10.1071/ah10955
Davidson, P. M., MacIsaac, A., Cameron, J., Jeremy, R., Mahar, L., & Anderson, I. (2012). Problems, Solutions and Actions: Addressing Barriers in Acute Hospital Care for Indigenous Australians and New Zealanders. Heart Lung and Circulation, 21(10), 639-643.
Davison, K. K., Lawson, H. A., & Coatsworth, J. D. (2012). The Family-Centered Action Model of Intervention Layout and Implementation (FAMILI): The Example of Childhood Obesity. Health PRomotion Practice, 13(4), 454-461. doi:10.1177/1524839910377966
Dawson, A. P., Cargo, M., Stewart, H., Chong, A., & Daniel, M. (2013). Identifying multi-level culturally appropriate smoking cessation strategies for Aboriginal health staff: a concept mapping approach. Health Education Research, 28(1), 31-45. doi:10.1093/her/cys111
De Jesus, M. (2010). Institutional Barriers and Strategies to Health Promotion: Perspectives and Experiences of Cape Verdean Women Health Promoters. Journal of Immigrant and Minority Health, 12(3), 398-407. doi:10.1007/s10903-008-9127-5
DeCou, C. R., Skewes, M. C., & Lopez, E. D. S. (2013). Traditional living and cultural ways as protective factors against suicide: perceptions of Alaska Native university students. International Journal of Circumpolar Health, 72, 142-146. doi:10.3402/ijch.v72i0.20968
Demaio, A., Drysdale, M., & de Courten, M. (2012). Appropriate health promotion for Australian Aboriginal and Torres Strait Islander communities: crucial for closing the gap. Global Health Promotion, 19(2), 58-62. doi:10.1177/1757975912441230
Denham, A. R. (2008). Rethinking Historical Trauma: Narratives of Resilience. Transcultural Psychiatry, 45(3), 391-414. doi:10.1177/1363461508094673
Denzin, N. K., & Lincoln, Y. S. (2011). The SAGE handbook of Qualitative Research. California: SAGE Publications.
DePue, J. D., Rosen, R. K., Batts-Turner, M., Bereolos, N., House, M., Forster, R. H., . . . McGarvey, S. T. (2010). Cultural Translation of Interventions: Diabetes Care in American Samoa. American Journal of Public Health, 100(11), 2085-2093. doi:10.2105/ajph.2009.170134
Desmarais, A. A., & Wittman, H. (2014). Farmers, foodies and First Nations: getting to food sovereignty in Canada. The Journal of Peasant Studies, 41(6), 1153-1173. doi:10.1080/03066150.2013.876623

DeVerteuil, G., & Wilson, K. (2010). Reconciling indigenous need with the urban welfare state? Evidence of culturally-appropriate services and spaces for Aboriginals in Winnipeg, Canada. Geoforum, 41(3), 498-507.
Dew, K., Scott, A., & Kirkman, A. (2016). The Health of Indigenous Communities. In Social, Political and Cultural Dimensions of Health (pp. 49-64). Cham: Springer International Publishing.
DiGiacomo, M., Davidson, P., Abbott, P., Davison, J., Moore, L., & Thompson, S. (2011). Smoking Cessation in Indigenous Populations of Australia, New Zealand, Canada, and the United States: Elements of Effective Interventions. International Journal of Environmental Research and Public Health, 8(2), 388-410.
Dlugonski, D., Das, B. M., & Martin, T. (2015). Increasing collective efficacy for physical activity: Design and rationale of Moms UNITE for Health. Contemporary Clinical Trials, 45, Part B, 233-238. doi:http://dx.doi.org/10.1016/j.cct.2015.09.003
Dockery, A. (2010). Culture and Wellbeing: The Case of Indigenous Australians. Social Indicators Research, 99(2), 315-332. doi:10.1007/s11205-010-9582-y
Dodgson, J. E., & Struthers, R. (2005). Indigenous Women's Voices: Marginalization and Health. Journal of Transcultural Nursing, 16(4), 339-346. doi:10.1177/1043659605278942
Doherty, S., Cawood, J., & Dooris, M. (2011). Applying the whole-system settings approach to food within universities. Perspectives in Public Health, 131(5), 217-224.
Donovan, D. M., Thomas, L. R., Sigo, R. L. W., Price, L., Lonczak, H., Lawrence, N., . . . Bagley, L. (2015). Healing of the Canoe: prelimary results of culturally grounded intervention to prevent substance abuse and promote tribal identity for Native youth in two Pacific northwest tribe. American Indian and Alaska native mental health research (Online), 22(1), 42-76.
Dooris, M. (2009). Holistic and sustainable health improvement: The contribution of the settings-based approach to health promotion. Perspectives in Public Health, 129(1), 29-36.
Dooris, M., & Newton, J. (2014). Theorizing healthy settings: a critical discussion with reference to Healthy Universities. Scandinavian journal of public health, 42(15 suppl), 7-16.
Draper, C., & Freedman, D. (2010). Review and Analysis of the Benefits, Purposes, and Motivations Associated with Community Gardening in the United States. Journal of Community Practice, 18(4), 458-492. doi:10.1080/10705422.2010.519682
Durey, A., & Thompson, S. C. (2012). Reducing the health disparities of Indigenous Australians: time to change focus. Bmc Health Services Research, 12. doi:151 10.1186/1472-6963-12-151
Durie, A. (1997). Te Aka Matua - Keeping a Maori identity. In P. TeWhaiti, M. McCarthy, & A. Durie (Eds.), Mai i Rangiatea. Auckland: Auckland University Press.
Durie, M. (1985). A Maori perspective of health. Social Science & Medicine, 20(5), 483-486. doi:10.1016/0277-9536(85)90363-6
Durie, M. (1989). The Treaty of Waitangi and health care. The New Zealand Medical Journal, 102, 283-285.
Durie, M. (1994). Whaiora: Maori health development. Auckland: Oxford University Press.
Durie, M. (1998). Te Mana, Te Kawangatanga - The Politics of Maori Self-Determination. Australia: Oxford University Press.
Durie, M. (2004). An Indigenous Model of Health Promotion. Paper presented at the 18th World Conference on Health Promotion and Health Education, Melbourne.
Durie, M. (2005). Indigenous health reforms: Best health outcomes for Maori in New Zealand. Paper presented at the Unleashing Innovation in Health Care Alberta's Symposium on Health, Calgary. http://www.massey.ac.nz/massey/fms/Te%20Mata%20O%20Te%20Tau/Publications%20-%20Mason/M%20Durie%20Indigenous%20Health%20reforms%20Best%20Health%20outcomes%20for%20Maori%20in%20New%20Zealand.pdf
Durie, M. (2006). Marae Encounters as a Basis for Understanding and Building Relationships. Paper presented at the Couple Relationships: Research and Practice Conference, New Zealand.
Durie, M. (2011). Indigenizing mental health services: New Zealand experience. Transcultural Psychiatry, 48(1-2), 24-36.
Durie, M. (2012). Indigenous health: New Zealand experience. MJA, 197(1), 10-11.
Dustin, D. L., Bricker, K. S., & Schwab, K. A. (2010). People and Nature: Toward an Ecological Model of Health Promotion. Leisure Sciences, 32(1), 3-14. doi:10.1080/01490400903430772
Dutta, M. (2007). Communicating about culture and health: Theorizing culture-centered and cultural sensitivity approaches. Communication Theory, 17(3), 304-328. doi:10.1111/j.1468-2885.2007.00297.x
Dutta, M. (2016). Cultural Context, Structural Determinants, and Global Health Inequities: The Role of Communication. Frontiers in Communication, 1(5). doi:10.3389/fcomm.2016.00005
Dutta, M., Anaele, A., & Jones, C. (2013). Voices of Hunger: Addressing Health Disparities Through the Culture-Centered Approach. Journal of Communication, 63(1), 159-180. doi:10.1111/jcom.12009
Dwyer, J., O'Donnell, K., Willis, E., & Kelly, J. (2016). Equitable Care for Indigenous People: every health service can do it. Asia Pacific Journal of Health Management, 11(3), 11.
Earle, M. (2011). Cultivating health: Community gardening as a public health intervention. (Master of Public Health Masters), University of Otago, Wellington
Earls, F. (2011). Toward a Science of Citizenship. American Journal of Orthopsychiatry, 81(4), 447-452. doi:10.1111/j.1939-0025.2011.01120.x
Eastman, C., & Marzillier, J. S. (1984). Theoretical and methodological difficulties in Bandura's self-efficacy theory. Cognitive Therapy and Research, 8(3), 213-229. doi:10.1007/bf01172994
Eckhardt, C. L., Lutz, T., Karanja, N., Jobe, J. B., Maupomé, G., & Ritenbaugh, C. (2014). Knowledge, attitudes, and beliefs that can influence infant feeding practices in American Indian mothers. Journal of the Academy of Nutrition and Dietetics, 114(10), 1587-1593.

Edgerly, C. C., Laing, S. S., Day, A.-V. G., Blackinton, P. M., Pingatore, N. L., Haverkate, R. T., & Heany, J. F. (2009). Steps to a Healthier Anishinaabe, Michigan: Strategies for Implementing Health Promotion Programs in Multiple American Indian Communities. Health PRomotion Practice, 10(2 suppl), 109S-117S. doi:10.1177/1524839908331270
Egli, V., Oliver, M., & Tautolo, E.-S. (2016). The development of a model of community garden benefits to wellbeing. Preventive Medicine Reports, 3, 348-352. doi:http://dx.doi.org/10.1016/j.pmedr.2016.04.005
Eizenberg, E. (2012). Actually Existing Commons: Three Moments of Space of Community Gardens in New York City. Antipode, 44(3), 764-782. doi:10.1111/j.1467-8330.2011.00892.x
Elliott, B., Jayatilaka, D., Brown, C., Varley, L., & Corbett, K. K. (2012). "We are not being heard": Aboriginal perspectives on traditional foods access and food security. Journal of environmental and public health, 2012.
Ellison-Loschmann, L., & Pearce, N. (2006). Improving access to health care among New Zealand's Maori population. American Journal of Public Health, 96(4), 612-617.
English, J., Wilson, K., & Keller-Olaman, S. (2008). Health, healing and recovery: Therapeutic landscapes and the everyday lives of breast cancer survivors. Social Science & Medicine, 67(1), 68-78. doi:10.1016/j.socscimed.2008.03.043
Esnard, C., & Roques, M. (2014). Collective efficacy: A resource in stressful occupational contexts. Revue Européenne de Psychologie Appliquée/European Review of Applied Psychology, 64(4), 203-211. doi:http://dx.doi.org/10.1016/j.erap.2014.05.003
Families Commission. (2011). Whānau yesterday, today, tomorrow. Retrieved from New Zealand: http://www.superu.govt.nz/sites/default/files/Wh%C4%81nau_yesterday%2C_today%2C_tomorrow.pdf
Fernandez-Ballesteros, R., Diez-Nicolas, J., Caprara, G. V., Barbaranelli, C., & Bandura, A. (2002). Determinants and structural relation of personal efficacy to collective efficacy. Applied Psychology, 51(1), 107-125.
Fernández-Ballesteros, R., Montenegro, E., Knoll, N., & Schwarzer, R. (2014). Self-efficacy, action control, and social support explain physical activity changes among Costa Rican older adults. Journal of Physical Activity and Health, 11(8), 1573-1578. doi:10.1123/jpah.2013-0175
Ferreira, M. S., & Castiel, L. D. (2009). Which empowerment, which Health Promotion? Conceptual convergences and divergences in preventive health practices. Cadernos de Saúde Pública, 25(1), 68-76.
Fiedeldey-Van Dijk, C., Rowan, M., Dell, C., Mushquash, C., Hopkins, C., Fornssler, B., . . . Shea, B. (2016). Honoring Indigenous culture-as-intervention: Development and validity of the Native Wellness AssessmentTM. Journal of Ethnicity in Substance Abuse, 1-38. doi:10.1080/15332640.2015.1119774
Firth, C., Maye, D., & Pearson, D. (2011). Developing "community" in community gardens. Local Environment, 16(6), 555-568.
Fitzgerald, A., Heary, C., Kelly, C., Nixon, E., & Shevlin, M. (2013). Self-efficacy for healthy eating and peer support for unhealthy eating are associated with adolescents' food intake patterns. Appetite, 63, 48-58. doi:10.1016/j.appet.2012.12.011
Flachs, A. (2010). Food for thought: The social impact of community gardens in the greater Cleveland area. Electronic Green Journal(30).
Flaschberger, E. (2013). Initial teacher education for school health promotion in Austria: Does it support the implementation of the health-promoting school approach? Health Education, 113(3), 216-231. doi:doi:10.1108/09654281311309846
Fletcher, K. M. (2005). Self-Efficacy as an Evaluation Measure for Programs in Support of Online Learning Literacies for Undergraduates. Internet and Higher Education, 8(4), 307-322.
Foley, W., Spurr, S., Lenoy, L., De Jong, M., & Fichera, R. (2011). Cooking skills are important competencies for promoting healthy eating in an urban Indigenous health service. Nutrition & Dietetics, 68(4), 291-296. doi:10.1111/j.1747-0080.2011.01551.x
Foote, K. E., & Azaryahu, M. (2009). Sense of place. International Encyclopedia of Human Geography, 96-100.
Forster, M. (2011). Kaitiakitanga: A Maori Environmental Ethic. In H. Tomlins Jahnke & M. Mulholland (Eds.), Mana Tangata - Politics of Empowerment (pp. 221-241). Wellington: Huia Publishers.
Freemantle, J., Ring, I., Arambula Solomon, T. G., Gachupin, F. C., Smylie, J., Cutler, T. L., & Waldon, J. A. (2014). Indigenous Mortality (Revealed): The Invisible Illuminated. American Journal of Public Health, 105(4), 644-652. doi:10.2105/AJPH.2014.301994
French, D. P. (2015). Self-Efficacy and Health In International Encyclopedia of the Social & Behavioral Sciences (Second Edition) (pp. 509-514). Oxford: Elsevier.
Friedman, L. (2006). What is psychoanalysis? The Psychoanalytic Quarterly, LXXV(3), 689-713. doi:10.1002/j.2167-4086.2006.tb00054.x
Friesen, B. J., Cross, T. L., Jivanjee, P., Thirstrup, A., Bandurraga, A., Gowen, L. K., & Rountree, J. (2015). Meeting the Transition Needs of Urban American Indian/Alaska Native Youth through Culturally Based Services. The Journal of Behavioral Health Services & Research, 42(2), 191-205. doi:10.1007/s11414-014-9447-2
Furey, L. (2006). Māori gardening - An archaeological perspective. Retrieved from Wellington:
Gates, A., Hanning, R. M., Gates, M., & Tsuji, L. J. (2016). The Food and Nutrient Intakes of First Nations Youth Living in Northern Ontario, Canada: Evaluation of a Harvest Sharing Program. Journal of Hunger & Environmental Nutrition, 11(4), 491-508.
Geana, M. V., Greiner, K. A., Cully, A., Talawyma, M., & Daley, C. M. (2012). Improving Health Promotion to American Indians in the Midwest United States: Preferred Sources of Health Information and Its Use for the Medical Encounter. Journal of Community Health, 37(6), 1253-1263. doi:10.1007/s10900-012-9564-x
Gendron, F., Hancherow, A., & Norton, A. (2016). Exploring and revitalizing Indigenous food networks in Saskatchewan, Canada, as a way to improve food security. Health Promotion International. doi:10.1093/heapro/daw013

George, L. (2010). Tradition, Invention, and Innovation: Multiple Reflections of an Urban Marae. (Doctor in Philosophy), Massey University, Auckland. Retrieved from http://muir.massey.ac.nz/handle/10179/1251
George, L. (2012). Expressions of Māori multiplicity in (re)connection to ngā taonga tuku iho. Social Identities, 18(4), 435-450.
Gerlach, A. J., Browne, A. J., & Greenwood, M. (2017). Engaging Indigenous families in a community-based Indigenous early childhood programme in British Columbia, Canada: A cultural safety perspective. Health & Social Care in the Community, 1-11.
Gesler, W. M. (1992). Therapeutic landscapes: Medical issues in light of the new cultural geography. Social Science & Medicine, 34(7), 735-746. doi:10.1016/0277-9536(92)90360-3
Gesler, W. M. (2009). Therapeutic Landscapes. In K. Editors-in-Chief: Rob & T. Nigel (Eds.), International Encyclopedia of Human Geography (pp. 229-230). Oxford: Elsevier.
Ghose, R., & Pettygrove, M. (2014a). Urban Community Gardens as Spaces of Citizenship. Antipode.
Ghose, R., & Pettygrove, M. (2014b). Actors and networks in urban community garden development. Geoforum, 53(0), 93-103. doi:http://dx.doi.org/10.1016/j.geoforum.2014.02.009
Gibbs, S., & Powell, B. (2012). Teacher efficacy and pupil behaviour: The structure of teachers' individual and collective beliefs and their relationship with numbers of pupils excluded from school. British Journal of Educational Psychology, 82(4), 564-584. doi:10.1111/j.2044-8279.2011.02046.x
Gibson, C. B., & Earley, P. C. (2007). Collective cognition in action: Accumulation, interaction, examination, and accommodation in the development and operation of group efficacy beliefs in the workplace. Academy of Management Review, 32(2), 438-458.
Gillies, A. (2011). The Maori Health Workforce: A historical overview. In H. Tomlins Jahnke & M. Mulholland (Eds.), Mana Tangata - Politics of Empowerment (pp. 195-218). Wellington: Huia Publishers.
Gillies, A., & Barnett, S. (2012). Maori Kuia in Aotearoa/New Zealand: Perceptions of marae and how marae affects their health. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 10(1).
Gittelsohn, J., & Rowan, M. (2011). Preventing diabetes and obesity in American Indian communities: the potential of environmental interventions. The American Journal of Clinical Nutrition, 93(5), 1179S-1183S. doi:10.3945/ajcn.110.003509
Goldberg, D. S. (2012). Social Justice, Health Inequalities and Methodological Individualism in US Health Promotion. Public Health Ethics, 5(2), 104-115. doi:10.1093/phe/phs013
Goncalo, J. A., Polman, E., & Maslach, C. (2010). Can confidence come too soon? Collective efficacy, conflict and group performance over time. Organizational Behavior and Human Decision Processes, 113(1), 13-24. doi:http://dx.doi.org/10.1016/j.obhdp.2010.05.001
Gone, J. P. (2011a). The Red Road to Wellness: Cultural Reclamation in a Native First Nations Community Treatment Center. American Journal of Community Psychology, 47(1-2), 187-202. doi:10.1007/s10464-010-9373-2
Gone, J. P. (2012). Indigenous Traditional Knowledge and Substance Abuse Treatment Outcomes: The Problem of Efficacy Evaluation. American Journal of Drug and Alcohol Abuse, 38(5), 493-497. doi:10.3109/00952990.2012.694528
Gone, J. P. (2013). Redressing First Nations historical trauma: Theorizing mechanisms for indigenous culture as mental health treatment. Transcultural Psychiatry, 50(5), 683-706. doi:doi:10.1177/1363461513487669
Goodkind, J. R., Gorman, B., Hess, J. M., Parker, D. P., & Hough, R. L. (2015). Reconsidering Culturally Competent Approaches to American Indian Healing and Well-Being. Qualitative Health Research, 25(4), 486-499. doi:10.1177/1049732314551056
Goodkind, J. R., Hess, J. M., Gorman, B., & Parker, D. P. (2012). “We’re Still in a Struggle”: Diné Resilience, Survival, Historical Trauma, and Healing. Qualitative Health Research, 22(8), 1019-1036. doi:10.1177/1049732312450324
Gould, G. S., Stevenson, L. C., Cadet-James, Y., & Clough, A. R. (2016). Cultural challenges when developing anti-tobacco messages for Indigenous Australians. Health Promotion International, daw072.
Gracey, M. (2014). Why closing the Aboriginal health gap is so elusive. Internal Medicine Journal, 44(11), 1141-1143. doi:10.1111/imj.12577
Gracey, M., & King, M. (2009). Indigenous health part 1: determinants and disease patterns. The Lancet, 374(9683), 65-75. doi:http://dx.doi.org/10.1016/S0140-6736(09)60914-4
Green, B. L. (2010). Culture Is Treatment Considering Pedagogy in the Care of Aboriginal People. Journal of Psychosocial Nursing and Mental Health Services, 48(7), 27-34. doi:10.3928/02793695-20100504-04
Green, J., & Thorogood, N. (2009). Qualitative Methods for Health Research. London: SAGE Publications Ltd.
Greenwood, M. L., & de Leeuw, S. N. (2012). Social determinants of health and the future well-being of Aboriginal children in Canada. Paediatrics & Child Health, 17(7), 381-384.
Grey, S., & Patel, R. (2015). Food sovereignty as decolonization: some contributions from Indigenous movements to food system and development politics. Agriculture and Human Values, 32(3), 431-444.
Gross, H., & Lane, N. (2007). Landscapes of the lifespan: Exploring accounts of own gardens and gardening. Journal of Environmental Psychology, 27(3), 225-241. doi:http://dx.doi.org/10.1016/j.jenvp.2007.04.003
Guitart, D., Pickering, C., & Byrne, J. (2012). Past results and future directions in urban community gardens research. Urban Forestry & Urban Greening, 11(4), 364-373. doi:http://dx.doi.org/10.1016/j.ufug.2012.06.007
Guthman, J. (2008). Bringing good food to others: investigating the subjects of alternative food practice. Cultural Geographies, 15(4), 431-447. doi:10.1177/1474474008094315
Guthman, J. (2009). Teaching the Politics of Obesity: Insights into Neoliberal Embodiment and Contemporary Biopolitics. Antipode, 41(5), 1110-1133. doi:10.1111/j.1467-8330.2009.00707.x
Guthman, J. (2011). Weighing In. Berkley: University of California Press.

Guthman, J. (2013). Fatuous measures: the artifactual construction of the obesity epidemic. Critical Public Health, 23(3), 263-273. doi:10.1080/09581596.2013.766670
Hagman, L. W. (2006). Cultural Self-efficacy of licensed registered nurses in New Mexico. Journal of Cultural Diversity, 13(2), 105-112.
Halbert, C. H., Bellamy, S., Briggs, V., Bowman, M., Delmoor, E., Kumanyika, S., . . . Johnson, J. C. (2013). Collective Efficacy and Obesity-Related Health Behaviors in a Community Sample of African Americans. Journal of Community Health, 1-8.
Hale, J., Knapp, C., Bardwell, L., Buchenau, M., Marshall, J., Sancar, F., & Litt, J. S. (2011). Connecting food environments and health through the relational nature of aesthetics: Gaining insight through the community gardening experience. Social Science & Medicine, 72(11), 1853-1863. doi:10.1016/j.socscimed.2011.03.044
Hall, K. S., & McAuley, E. (2010). Individual, social environmental and physical environmental barriers to achieving 10 000 steps per day among older women. Health Education Research, 25(3), 478-488. doi:10.1093/her/cyq019
Hallberg, B. (2009). Using Community Gardens to Augment Food Security Efforts in Low-Income Communities. (Masters), Virginia Tech,
Hamerton, H., Mercer, C., Riini, D., McPherson, B., & Morrison, L. (2014). Evaluating Māori community initiatives to promote Healthy Eating, Healthy Action. Health Promotion International, 29(1), 60-69.
Hammell, K. R. W. (2014). Belonging, occupation, and human well-being: An exploration. Canadian Journal of Occupational Therapy-Revue Canadienne D Ergotherapie, 81(1), 39-50. doi:10.1177/0008417413520489
Hancock, T. (2011). Health promotion in Canada: 25 years of unfulfilled promise. Health Promotion International, 26(suppl 2), ii263-ii267. doi:10.1093/heapro/dar061
Hanna, A. K., & Oh, P. (2000). Rethinking Urban Poverty: A Look at Community Gardens. Bullletin of Science, Technology & Society, 20(3), 207-216.
Hardin, J. (2015). Everyday translation: health practitioners' perspectives on obesity and metabolic disorders in Samoa. Critical Public Health, 25(2), 125-138. doi:10.1080/09581596.2014.909581
Hargreaves, R. (1963). Changing Maori agriculture in pre-Waitangi New Zealand. The Journal of the Polynesian Society, 101-117.
Harris, N., Minniss, F. R., & Somerset, S. (2014). Refugees Connecting with a New Country through Community Food Gardening. International Journal of Environmental Research and Public Health, 11(9), 9202-9216. doi:10.3390/ijerph110909202
Harris, S. B., Bhattacharyya, O., Dyck, R., Hayward, M. N., & Toth, E. L. (2013). Type 2 Diabetes in Aboriginal Peoples. Canadian Journal of Diabetes, 37, Supplement 1(0), S191-S196. doi:http://dx.doi.org/10.1016/j.jcjd.2013.01.046
Hart, M. A. (2010). Indigenous worldviews, knowledge, and research: The development of an indigenous research paradigm. Journal of Indigenous Voices in Social Work, 1(1), 1-16.
Hartmann, W. E. (2016). Ideas of culture in an urban American Indian Behavioral Health Clinic. (Doctor of Philosophy Doctorate), University of Michigan, United States of America.
Hartmann, W. E., & Gone, J. P. (2012). Incorporating Traditional Healing Into an Urban American Indian Health Organization: A Case Study of Community Member Perspectives. Journal of Counseling Psychology, 59(4), 542-554. doi:10.1037/a0029067
Hartwig, K. A., & Mason, M. (2016). Community Gardens for Refugee and Immigrant Communities as a Means of Health Promotion. Journal of Community Health.
Haswell, M., Fitzpatrick, S. A., & Jackson Pulver, L. (2011). Healing, empowerment and resilience across the lifespan: views from an academic unit. Dialogue (Academy of the Social Sciences in Australia), 30(2), 36.
Hatchett, L., Brown, L., Hopkins, J., Larsen, K., & Fournier, E. (2015). "Something Good Can Grow Here": Chicago Urban Agriculture Food Projects. Journal of prevention & intervention in the community, 43(2), 135-147.
Heart, M., Chase, J., Elkins, J., & Altschul, D. (2011). Historical Trauma Among Indigenous Peoples of the Americas: Concepts, Research, and Clinical Considerations. Journal of Psychoactive Drugs, 43(4), 282-290. doi:10.1080/02791072.2011.628913
Heil, D. (2006). Shifting Expectations of Treatment: From 'Patient as Individual' to 'Patient as Social Person'. Australian Aboriginal Studies(2), 98-110.
Henderson, B. R., & Hartsfield, K. (2009). Is getting into the community garden business a good way to engage citizens in local government? National Civic Review, 98(4), 12-17.
Henderson, S., & Kendall, E. (2011). Culturally and linguistically diverse peoples' knowledge of accessibility and utilisation of health services: exploring the need for improvement in health service delivery. Australian Journal of Primary Health, 17(2), 195-201. doi:10.1071/py10065
Herring, S., Spangaro, J., Lauw, M., & McNamara, L. (2013). The Intersection of Trauma, Racism, and Cultural Competence in Effective Work with Aboriginal People: Waiting for Trust. Australian Social Work, 66(1), 104-117.
Hevey, D., Smith, M. l., & McGee, H. M. (1998). Self-efficacy and health behaviour: A review. The Irish Journal of Psychology, 19(2-3), 248-273. doi:10.1080/03033910.1998.10558189
Hickman, P. (2013). "Third places" and social interaction in deprived neighbourhoods in Great Britain. Journal of Housing and the Built Environment, 28(2), 221-236. doi:10.1007/s10901-012-9306-5
Hill, D. L. (2006). Sense of belonging as connectedness, American Indian worldview and mental health. Archives of Psychiatric Nursing, 20(5), 210-216. doi:10.1016/j.apnu.2006.04.003

Hill, R. S. (2010). Maori and the State: Crown–Maori Relations in New Zealand/Aotearoa, 1950–2000: Victoria University Press.
Hill, R. S. (2012). Maori urban migration and the assertion of indigeneity in Aotearoa/New Zealand, 1945-1975. Interventions, 14(2), 256-278.
Hill, R. S. (2016). New Zealand Maori: The Quest for Indigenous Autonomy. Ethnopolitics, 15(1), 144-165. doi:10.1080/17449057.2015.1101844
Hiroa, T. R. (1927). The material culture of the Cook Islands (Aitutaki). New Plymouth: Thomas Avery and Sons Limited.
Hodge, D. R., Jackson, K. F., & Vaughn, M. G. (2010). Culturally Sensitive Interventions and Health and Behavioral Health Youth Outcomes: A Meta-Analytic Review. Social Work in Health Care, 49(5), 401-423. doi:10.1080/00981381003648398
Hong, S.-y. (2011). Understanding exercise adherence in the Intergenerational Physical Activity program: A theoretical perspective. Pacific Science Review, 13(2), 109-116.
Houkamau, C. A., & Sibley, C. G. (2010). The Multi-Dimensional Model of Māori Identity and Cultural Engagement. New Zealand Journal of Psychology, 39(1), 8-28.
Houkamau, C. A., & Sibley, C. G. (2011). Maori Cultural Efficacy and Subjective Wellbeing: A Psychological Model and Research Agenda. Social Indicators Research, 103(3), 379-398. doi:10.1007/s11205-010-9705-5
Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). Te Ara Tika - Guidelines for Maori Research Ethics: A framework for researchers and ethics committee members. Auckland: Health Research Council of New Zealand.
Huffman, M. D., & Galloway, J. M. (2010). Cardiovascular Health in Indigenous Communities: Successful Programs. Heart, Lung and Circulation, 19(5–6), 351-360. doi:http://dx.doi.org/10.1016/j.hlc.2010.02.013
Hume, A., O'Dea, K., & Brimblecombe, J. (2013). "We need our own food, to grow our own veggies ... " Remote Aboriginal food gardens in the Top End of Australia's Northern Territory. Australian and New Zealand Journal of Public Health, 37(5), 434-441. doi:10.1111/1753-6405.12103
Hume, A., O'Dea, K., & Brimblecombe, J. K. (2013). A survey of remote Aboriginal horticulture and community gardens in the Northern Territory. Australian and New Zealand Journal of Public Health, 37(4), 394-395. doi:10.1111/1753-6405.12054
Hunter, D. J., Popay, J., Tannahill, C., & Whitehead, M. (2010). Getting to grips with health inequalities at last? BMJ, 340. doi:10.1136/bmj.c684
Hutchings, J., Tipene, P., Carney, G., Greensill, A., Skelton, P., & Baker, M. (2012). Hua Parakore: An indigenous food sovereignty initiative and hallmark of excellence for food and product production. MAI Journal, 1(2).
Imayama, I., Alfano, C. M., Mason, C. E., Wang, C., Xiao, L., Duggan, C., . . . McTiernan, A. (2013). Exercise adherence, cardiopulmonary fitness, and anthropometric changes improve exercise self-efficacy and health-related quality of life. Journal of Physical Activity and Health, 10(5), 676-689.
Imbellone, A., & Laghi, F. (2016). The role of time perspective in social cognitive career theory of interests. Time & Society, 25(2), 334-354. doi:10.1177/0961463x15577263
Indian Health Service. (2015). Urban Indian Health Program. IHS Fact Sheet. Retrieved from www.ihs.gov
Ivert, A.-K., & Levander, M. T. (2014). Adolescents' Perceptions of Neighbourhood Social Characteristics—Is There a Correlation with Mental Health? Child Indicators Research, 7(1), 177-192. doi:10.1007/s12187-013-9210-x
Iwasaki, Y., & Byrd, N. G. (2010). Cultural Activities, Identities, and Mental Health Among Urban American Indians with Mixed Racial/Ethnic Ancestries. Race and Social Problems, 2(2), 101-114. doi:10.1007/s12552-010-9028-9
Jackson, A.-M. (2015). Kaupapa Maori theory and critical discourse analysis: Transformation and social change. AlterNative: An International Journal of Indigenous Peoples, 11(3), 256.
Jansen, P., & Jansen, D. (2013). The influence of Place and Culture on practice-based learning - Focus on marae learning. In J. Higgs, D. Sheehan, J. Baldry Currens, W. Letts, & G. M. Jensen (Eds.), Realising Exemplary Practice-Based Education (pp. 257-264). The Netherlands: Sense Publisher.
Johnson, D. R., McDermott, R. A., Clifton, P. M., D'Onise, K., Taylor, S. M., Preece, C. L., & Schmidt, B. A. (2015). Characteristics of Indigenous adults with poorly controlled diabetes in north Queensland: implications for services. Bmc Public Health, 15, 325. doi:10.1186/s12889-015-1660-2
Johnston, V., & Thomas, D. P. (2010). What works in Indigenous tobacco control? The perceptions of remote Indigenous community members and health staff. Health Promotion Journal of Australia, 21(1), 45-50.
Jones, B., Ingham, T. R., Cram, F., Dean, S., & Davies, C. (2013). An indigenous approach to explore health-related experiences among Maori parents: the Pukapuka Hauora asthma study. Bmc Public Health, 13. doi:10.1186/1471-2458-13-228
Kakudate, N., Morita, M., Fukuhara, S., Sugai, M., Nagayama, M., Kawanami, M., & Chiba, I. (2010). Application of self-efficacy theory in dental clinical practice. Oral Diseases, 16(8), 747-752. doi:10.1111/j.1601-0825.2010.01703.x
Kamal, A. G., Linklater, R., Thompson, S., Dipple, J., & Committee, I. M. (2015). A recipe for change: reclamation of Indigenous food sovereignty in O-Pipon-Na-Piwin Cree Nation for decolonization, resource sharing, and cultural restoration. Globalizations, 12(4), 559-575.
Kamal, A. G., & Thompson, S. (2013). Recipe for decolonization and resurgence: Story of O-Pipon-Na-Piwin Cree Nation's indigenous food sovereignty movement. Paper presented at the Conference Paper.
Karasek, D., Ahern, J., & Galea, S. (2012). Social Norms, Collective Efficacy, and Smoking Cessation in Urban Neighborhoods. American Journal of Public Health, 102(2), 343-351. doi:10.2105/ajph.2011.300364

Kassa, I. B. (2016). You Are What You (Can) Eat: Cultivating Resistance through Food, Justice, and Gardens on the South Side of Chicago. (Bachelor of Arts Degree in Environmental Analysis), Pomona College, California Retrieved from http://scholarship.claremont.edu/pomona_theses/141
Kawharu, I. H. (1989). Waitangi: Māori & Pākehā Perspectives of the Treaty of Waitangi: Oxford University Press.
Kawharu, M. (2010). Environment as a marae locale. In R. Selby, P. Moore, & M. Mulholland (Eds.), Kaitiaki: Maori and the Environment (pp. 221-237). Wellington: Huia.
Kearns, A., & Forrest, R. (2000). Social cohesion and multilevel urban governance. Urban Studies, 37(5-6), 995-1017.
Kearns, R., & Collins, D. (2009). Health Geography. In T. Brown, S. McLafferty, & G. Moon (Eds.), A companion to medical and health geography (pp. 15-32). Oxford: Oxford University Press.
Kelley, A., Belcourt-Dittloff, A., Belcourt, C., & Belcourt, G. (2013). Research ethics and indigenous communities. American Journal of Public Health, 103(12), 2146-2152.
Kelly, J., Saggers, S., Taylor, K., Pearce, G., Massey, P., Bull, J., . . . Ahboo, S. (2012). "Makes you proud to be black eh?": Reflections on meaningful Indigenous research participation. International Journal for Equity in Health, 11, 8. doi:10.1186/1475-9276-11-40
Kendall, E., & Barnett, L. (2015). Principles for the development of Aboriginal health interventions: culturally appropriate methods through systemic empathy. Ethnicity & Health, 20(5), 437-452. doi:10.1080/13557858.2014.921897
Kenyon, D. B., & Hanson, J. D. (2012). Incorporating Traditional Culture Into Positive Youth Development Programs With American Indian/Alaska Native Youth. Child Development Perspectives, 6(3), 272-279. doi:10.1111/j.1750-8606.2011.00227.x
Khalil, C. B., Johnson-Down, L., & Egeland, G. M. (2010). Emerging obesity and dietary habits among James Bay Cree youth. Public Health Nutrition, 13(11), 1829-1837.
King, M. (1996). Maori - A Photographic and Social History (Revised ed.). Auckland: Reed Publishing.
King, M., Smith, A., & Gracey, M. (2009). Indigenous health part 2: the underlying causes of the health gap. The Lancet, 374(9683), 76-85. doi:10.1016/s0140-6736(09)60827-8
King, P., Hodgetts, D., Rua, M., & Te Whetu, T. (2015). Older men gardening on the marae: Everyday practices for being Maori AlterNative, 11(1), 14-28.
Kingi, T. (2005). Indigeneity and Māori Mental Health. Paper presented at the International Symposium: Indigenous Inspiration in Health, Copthorne Resort, Waitangi. http://www.massey.ac.nz/massey
Kingi, T. (2006). Culture, Health, and Maori Development. In Te Pūtahi-a-Toi - Te Mata o te Tau Lecture Series: Massey University. Retrieved from http://citeseerx.ist.psu.edu.
Kingi, T. (2007). The Treaty of Waitangi: A framework for Māori health development. New Zealand Journal of Occupational Therapy, 54(1), 4-10.
Kingsley, J., & Townsend, M. (2006). 'Dig In' to social capital: community gardens as mechanisms for growing urban social connectedness. Urban Policy and Research, 24(4), 525-537.
Kingsley, J., Townsend, M., & Henderson-Wilson, C. (2009). Cultivating health and wellbeing: members' perceptions of the health benefits of a Port Melbourne community garden. Leisure Studies, 28(2), 207-219. doi:10.1080/02614360902769894
Kingsley, J., Townsend, M., Henderson-Wilson, C., & Bolam, B. (2013). Developing an Exploratory Framework Linking Australian Aboriginal Peoples' Connection to Country and Concepts of Wellbeing. International Journal of Environmental Research and Public Health, 10(2), 678-698. doi:10.3390/ijerph10020678
Kingsley, J., Townsend, M., Phillips, R., & Aldous, D. (2009). “If the land is healthy … it makes the people healthy”: The relationship between caring for Country and health for the Yorta Yorta Nation, Boonwurrung and Bangerang Tribes. Health & Place, 15(1), 291-299. doi:10.1016/j.healthplace.2008.05.009
Kirmayer, L. J. (2012). Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. Social Science & Medicine, 75(2), 249-256.
Kirmayer, L. J., & Brass, G. (2016). Addressing global health disparities among Indigenous peoples. The Lancet, 388(10040), 105-106. doi:10.1016/S0140-6736(16)30194-5
Kirmayer, L. J., Dandeneau, S., Marshall, E., Phillips, M. K., & Williamson, K. J. (2011). Rethinking resilience from indigenous perspectives. Canadian Journal of Psychiatry, 56(2), 84-91.
Kirmayer, L. J., Simpson, C., & Cargo, M. (2003). Healing traditions: culture, community and mental health promotion with Canadian Aboriginal peoples. Australasian Psychiatry, 11, S15-S23. doi:10.1046/j.1038-5282.2003.02010.x
Kiro, C. (2001). Kimihia Hauora Māori - Māori Health Policy and Practice. (Doctor of Philiosophy), Massey University, Albany.
Kitayama, S., Markus, H. R., & Lieberman, C. (1995). The collective construction of self esteem: Implications for culture, self, and emotion. In J. A. Russell, J. M. Fernández-Dols, A. S. R. Manstead, & J. C. Wellenkamp (Eds.), Everyday conceptions of emotion: An introduction to the psychology, anthropology and linguistics of emotion (pp. 523-550). New York, NY, US: Kluwer Academic/Plenum Publishers.
Kite, E., & Davy, C. (2015). Using Indigenist and Indigenous methodologies to connect to deeper understandings of Aboriginal and Torres Strait Islander peoples’ quality of life. Health Promotion Journal of Australia, 26(3), 191-194. doi:http://dx.doi.org/10.1071/HE15064
Klassen, R. M. (2004). Optimism and realism: A review of self-efficacy from a cross-cultural perspective. International Journal of Psychology, 39(3), 205-230.
Kocher, E. L., Sternberg Lamb, J. M., McGarvey, S. T., Faiai, M. u., Muasau-Howard, B. T., & Hawley, N. L. (2017). Conceptions of pregnancy health and motivations for healthful behavior change among women in American Samoa. Women and Birth, IN PRESS. doi:http://dx.doi.org/10.1016/j.wombi.2017.06.011

Kokko, S., Green, L. W., & Kannas, L. (2014). A review of settings-based health promotion with applications to sports clubs. Health Promotion International, 29(3), 494-509.
Kortright, R., & Wakefield, S. (2010). Edible backyards: a qualitative study of household food growing and its contributions to food security. Agriculture and Human Values, 28(1), 39-53.
Kovach, M. (2009). Indigenous Methodologies - Characteristics, conversations, and contexts. Toronto: University of Toronto Press Incorporated 2009.
Kovach, M. (2010). Conversational method in Indigenous research. First Peoples Child & Family Review, 5(1), 40-48.
Kovach, M. (2015). Emerging from the margins: Indigenous methodologies. Research as Resistance, 2e: Revisiting Critical, Indigenous, and Anti-Oppressive Approaches, 43.
Kowal, E. E., & Paradies, Y. C. (2010). Enduring dilemmas of Indigenous health. The Medical Journal of Australia, 192(10), 599-599.
Kral, M. J., & Idlout, L. (2012). It's All in the Family: Wellbeing Among Inuit in Arctic Canada. In H. Selin & G. Davey (Eds.), Happiness Across Cultures: Views of Happiness and Quality of Life in Non-Western Cultures (pp. 387-398). Dordrecht: Springer Netherlands.
Kral, M. J., Idlout, L., Minore, J. B., Dyck, R. J., & Kirmayer, L. J. (2011). Unikkaartuit: Meanings of Well-Being, Unhappiness, Health, and Community Change Among Inuit in Nunavut, Canada. American Journal of Community Psychology, 48(3-4), 426-438.
Kukutai, T. (2013). The Structure of Urban Maori Identities. In E. J. Peters & C. Andersen (Eds.), Indigenous in the City (pp. 311-333). Canada: UBC Press.
Kulis, S., Wagaman, M. A., Tso, C., & Brown, E. F. (2013). Exploring Indigenous Identities of Urban American Indian Youth of the Southwest. Journal of Adolescent Research, 28(3), 271-298. doi:10.1177/0743558413477195
Kumpfer, K., Magalhães, C., & Xie, J. (2017). Cultural Adaptation and Implementation of Family Evidence-Based Interventions with Diverse Populations. Prevention Science, 18(6), 649-659. doi:10.1007/s11121-016-0719-3
Kurtz, D. (2013). Indigenous methodologies: Traversing Indigenous and Western worldviews in research. AlterNative, 9(3), 217-229.
Labonté, R. (1989). Community empowerment: the need for political analysis. Canadian Journal of Public Health, 80(2), 87-88.
Lainer, J., Schumacher, J., & Calvert, K. (2015). Cultivating Community Collaboration and Community Health Through Community Gardens. Journal of Community Practice, 23, 492-507.
Laliberté, A., Haswell-Elkins, M., & Reilly, L. (2009). The healing journey: Empowering Aboriginal communities to close the health gap. Australasian Psychiatry, 17(SUPPL. 1), S64-S67.
Lange, R. (1999). May the People Live - A history of Maori health development 1900-1920. Auckland: Auckland University Press.
Lange, R. (2008). Te hauora Māori i mua – history of Māori health - Health devastated, 1769 to 1901. In Te Ara - the Encyclopedia of New Zealand. Online.
Lardon, C., Wolsko, C., Trickett, E., Henry, D., & Hopkins, S. (2016). Assessing Health in an Alaska Native Cultural Context: The Yup'ik Wellness Survey. Cultural Diversity & Ethnic Minority Psychology, 22(1), 126-136. doi:10.1037/cdp0000044
Larkey, L. K., & Hecht, M. (2010). A Model of Effects of Narrative as Culture-Centric Health Promotion. Journal of Health Communication, 15(2), 114-135. doi:10.1080/10810730903528017
Lashley, M. E. (2000). Implementing treaty settlements via indigenous institutions: Social justice and detribalization in New Zealand. The Contemporary Pacific, 12(1), 1-55.
Lavallée, L. F. (2009). Practical Application of an Indigenous Research Framework and Two Qualitative Indigenous Research Methods: Sharing Circles and Anishnaabe Symbol-Based Reflection International Journal of Qualitative Methods,, 8(1), 21-40.
Laverack, G., & Keshavarz Mohammadi, N. (2011). What remains for the future: strengthening community actions to become an integral part of health promotion practice. Health Promotion International, 26(suppl 2), ii258-ii262. doi:10.1093/heapro/dar068
Laverack, G., & Wallerstein, N. (2001). Measuring community empowerment: a fresh look at organizational domains. Health Promotion International, 16(2), 179-185.
Lawson, L. J. (2005). City bountiful: A century of community gardening in America University of California Press.
Lawson, L. J. (2014). Garden for Victory! The American Victory Garden Campaign of World War II. In K. G. Tidball & M. E. Krasny (Eds.), Greening in the Red Zone (pp. 181-195): Springer Netherlands.
Laycock, A., Walker, D., Harrison, N., & Brands, J. (2011). Researching Indigenous health: a practical guide for researchers. Melbourne: The Lowitja Institute.
Le Grande, M., Ski, C. F., Thompson, D. R., Scuffham, P., Kularatna, S., Jackson, A. C., & Brown, A. (2017). Social and emotional wellbeing assessment instruments for use with Indigenous Australians: A critical review. Social Science & Medicine, 187, 164-173. doi:http://dx.doi.org/10.1016/j.socscimed.2017.06.046
Lee, C. (1989). Theoretical weaknesses lead to practical problems: The example of self-efficacy theory. Journal of Behavior Therapy and Experimental Psychiatry, 20(2), 115-123. doi:10.1016/0005-7916(89)90044-X
Lee, C. (1992). On cognitive theories and causation in human behavior. Journal of Behavior Therapy and Experimental Psychiatry, 23(4), 257-268. doi:10.1016/0005-7916(92)90048-N
Lee, L. L., Kuo, Y. C., Fanaw, D., Perng, S. J., & Juang, I. F. (2012). The effect of an intervention combining self-efficacy theory and pedometers on promoting physical activity among adolescents. Journal of Clinical Nursing, 21(7-8), 914-922. doi:10.1111/j.1365-2702.2011.03881.x
Lee, T. W., & Ko, Y. K. (2010). Effects of self-efficacy, affectivity and collective efficacy on nursing performance of hospital nurses. Journal of Advanced Nursing, 66(4), 839-848. doi:10.1111/j.1365-2648.2009.05244.x

Lengen, C., & Kistemann, T. (2012). Sense of place and place identity: Review of neuroscientific evidence. Health & Place, 18(5), 1162-1171. doi:10.1016/j.healthplace.2012.01.012
Lewis, T. (2011). Assessing social identity and collective efficacy as theories of group motivation at work. International Journal of Human Resource Management, 22(4), 963-980. doi:10.1080/09585192.2011.555136
Liamputtong, P., & Suwankhong, D. (2015). Therapeutic landscapes and living with breast cancer: The lived experiences of Thai women. Social Science & Medicine, 128(0), 263-271. doi:http://dx.doi.org/10.1016/j.socscimed.2015.01.031
Liaw, S. T., Lau, P., Pyett, P., Furler, J., Burchill, M., Rowley, K., & Kelaher, M. (2011). Successful chronic disease care for Aboriginal Australians requires cultural competence. Australian and New Zealand Journal of Public Health, 35(3), 238-248.
Lilley, S. (n.d). The Marae as an information ground. In. Retrieved from http://ibec.ischool.washington.edu/pubs/maraeInfoGround.pdf
Lindley, L. D. (2006). The Paradox of Self-Efficacy: Research With Diverse Populations. Journal of Career Assessment, 14(1), 143-160. doi:10.1177/1069072705281371
Litt, J. S., Soobader, M.-J., Turbin, M. S., Hale, J. W., Buchenau, M., & Marshall, J. A. (2011). The Influence of Social Involvement, Neighborhood Aesthetics, and Community Garden Participation on Fruit and Vegetable Consumption. American Journal of Public Health, 101(8), 1466-1473. doi:10.2105/ajph.2010.300111
Lohr, V., I, & Pearson, C., H. (2004). The Relative Influence of Childhood Activities and Demographics on Adult Appreciation for the Role of Trees in Human Well-Being International Society for Horticultural Science (Online).
Lombard, K. A., Beresford, S. A. A., Ornelas, I. J., Topaha, C., Becenti, T., Thomas, D., & Vela, J. G. (2014). Healthy Gardens/Healthy Lives: Navajo Perceptions of Growing Food Locally to Prevent Diabetes and Cancer. Health PRomotion Practice, 15(2), 223-231. doi:10.1177/1524839913492328
Love, M., Wilton, R., & DeVerteuil, G. (2012). 'You have to make a new way of life': women's drug treatment programmes as therapeutic landscapes in Canada. Gender Place and Culture, 19(3), 382-396. doi:10.1080/0966369x.2011.609985
Lowell, A., Kildea, S., Liddle, M., Cox, B., & Paterson, B. (2015). Supporting aboriginal knowledge and practice in health care: lessons from a qualitative evaluation of the strong women, strong babies, strong culture program. BMC Pregnancy and Childbirth, 15(1), 19. doi:10.1186/s12884-015-0433-3
MacDonald, C., & Steenbeek, A. (2015). The Impact of Colonization and Western Assimilation on Health and Wellbeing of Canadian Aboriginal People. International Journal of Regional and Local History, 10(1), 32-46. doi:10.1179/2051453015Z.00000000023
Maddux, J. (2012). Self-Efficacy: The Power of Believing You Can. In S. Lopez & C. Synder (Eds.), The Oxford Handbook of Positive Psychology (2nd ed., pp. 1-23): Oxford Handbooks Online (July 2009). doi:10.1093/oxfordhb/9780195187243.001.0001
Mahayuddin, S. A., Zaharuddin, W. A. Z. W., Harun, S. N., & Ismail, B. (2017). Assessment of Building Typology and Construction Method of Traditional Longhouse. Procedia Engineering, 180, 1015-1023. doi:http://dx.doi.org/10.1016/j.proeng.2017.04.261
Maimon, D., & Browning, C. R. (2012). Underage drinking, alcohol sales and collective efficacy: Informal control and opportunity in the study of alcohol use. Social Science Research, 41(4), 977-990. doi:http://dx.doi.org/10.1016/j.ssresearch.2012.01.009
Maimon, D., Browning, C. R., & Brooks-Gunn, J. (2010). Collective Efficacy, Family Attachment, and Urban Adolescent Suicide Attempts. Journal of Health and Social Behavior, 51(3), 307-324.
Mangadu, T., Kelly, M., Orezzoli, M. C. E., Gallegos, R., & Matharasi, P. (2016). Best practices for community gardening in a US–Mexico border community. Health Promotion International. doi:10.1093/heapro/daw025
Manukau City Council. (1985). Approval of urban marae project. BANC A736 1364 Box 19 NZ Archives.
Māori Law Review. (2014). Special Issue – The Tūhoe-Crown Settlement. October.
Mariño, R., Calache, H., & Morgan, M. (2013). A Community-Based Culturally Competent Oral Health Promotion for Migrant Older Adults Living in Melbourne, Australia. Journal of the American Geriatrics Society, 61(2), 270-275. doi:10.1111/jgs.12078
Markus, H. R., & Kitayama, S. (2010). Cultures and Selves: A Cycle of Mutual Constitution. Perspectives on Psychological Science, 5(4), 420-430. doi:10.1177/1745691610375557
Marley, J. V., Atkinson, D., Kitaura, T., Nelson, C., Gray, D., Metcalf, S., & Maguire, G. P. (2014). The Be Our Ally Beat Smoking (BOABS) study, a randomised controlled trial of an intensive smoking cessation intervention in a remote aboriginal Australian health care setting. Bmc Public Health, 14(1), 32.
Marquina-Márquez, A., Virchez, J., & Ruiz-Callado, R. (2016). Postcolonial healing landscapes and mental health in a remote Indigenous community in subarctic Ontario, Canada. Polar Geography, 39(1), 20-39. doi:10.1080/1088937X.2016.1155673
Marsh, T. N., Cote-Meek, S., Toulouse, P., Najavits, L. M., & Young, N. L. (2015). The Application of Two-Eyed Seeing Decolonizing Methodology in Qualitative and Quantitative Research for the Treatment of Intergenerational Trauma and Substance Use Disorders. International Journal of Qualitative Methods, 14(5), 1-13.
Marshall, C., & Rossman, G. B. (2014). Designing qualitative research: Sage publications.
Martens, T., Cidro, J., Hart, M. A., & McLachlan, S. (2015). Understanding Indigenous Food Sovereignty through an Indigenous Research Paradigm. Journal of Indigenous Social Development, 5(1).
Martin, K., & Mirraboopa, B. (2003). Ways of knowing, being and doing: A theoretical framework and methods for indigenous and indigenist re-search. Journal of Australian Studies, 27(76), 203-214.

Marzillier, J., & Eastman, C. (1984). Continuing problems with self-efficacy theory: A reply to Bandura. Cognitive Therapy and Research, 8(3), 257-262. doi:10.1007/BF01172996
Masuda, J. R., & Crabtree, A. (2010). Environmental justice in the therapeutic inner city. Health and Place, 16(4), 656-665. doi:10.1016/j.healthplace.2010.02.003
Matsuo, T., Murotake, Y., Kim, M. J., Akiba, T., Shimojo, N., Kim, M. K., & Tanaka, K. (2010). High general self-efficacy is associated with less weight loss under a supervised dietary modification program. Obesity Research & Clinical Practice, 4(2), E135-E144. doi:10.1016/j.orcp.2009.12.002
Mazumdar, S., & Mazumdar, S. (2012). Immigrant home gardens: Places of religion, culture, ecology, and family. Landscape and Urban Planning, 105(3), 258-265. doi:http://dx.doi.org/10.1016/j.landurbplan.2011.12.020
McCalman, J., Tsey, K., Bainbridge, R., Rowley, K., Percival, N., O'Donoghue, L., . . . Judd, J. (2014). The characteristics, implementation and effects of Aboriginal and Torres Strait Islander health promotion tools: a systematic literature search. Bmc Public Health, 14(1), 1-12. doi:10.1186/1471-2458-14-712
McClintock, N. (2013). Radical, reformist, and garden-variety neoliberal: coming to terms with urban agriculture's contradictions. Local Environment, 1-25. doi:10.1080/13549839.2012.752797
McDonald, E., Slavin, N., Bailie, R., & Schobben, X. (2011). No germs on me: a social marketing campaign to promote hand-washing with soap in remote Australian Aboriginal communities. Global Health Promotion, 18(1), 62-65. doi:doi:10.1177/1757975910393577
McIvor, D. W., & Hale, J. (2015). Urban agriculture and the prospects for deep democracy. Agriculture and Human Values, 32(4), 727-741. doi:10.1007/s10460-015-9588-9
McKerchar, C., Bowers, S., Heta, C., Signal, L., & Matoe, L. (2014). Enhancing Māori food security using traditional kai. Global Health Promotion.
McPhail-Bell, K., Bond, C., Brough, M., & Fredericks, B. (2015). "We don't tell people what to do': ethical practice and Indigenous health promotion. Health Promotion Journal of Australia, 26(3), 195-199. doi:10.1071/he15048
McQueen, D. V. (2011). A challenge for health promotion. Global Health Promotion, 18(2), 8-9.
McQueen, D. V., & De Salazar, L. (2011). Health promotion, the Ottawa Charter and 'developing personal skills': A compact history of 25 years. Health Promotion International, 26(SUPPL. 2), ii194-ii201.
McQueen, D. V., & Jones, C. M. (Eds.). (2007). Global Perspectives on Health Promotion Effectiveness. New York: Springer.
Mead, E. L., Gittelsohn, J., Roache, C., Corriveau, A., & Sharma, S. (2013). A Community-Based, Environmental Chronic Disease Prevention Intervention to Improve Healthy Eating Psychosocial Factors and Behaviors in Indigenous Populations in the Canadian Arctic. Health Education and Behavior, 40(5), 592-602.
Mead, H. M. (2003). Tikanga Maori - Living by Maori values. Wellington: Huia Publishers.
Mennis, J., Dayanim, S. L., & Grunwald, H. (2013). Neighborhood collective efficacy and dimensions of diversity: A multilevel analysis. Environment and Planning A, 45(9), 2176-2193.
Meredith, P. (2000). Urban Maori as 'New Citizens': The Quest for Recognition and Resources. Draft, 25. Retrieved from http://lianz.waikato.ac.nz/PAPERS/paul/URBAN%20MAORI.pdf
Milbourne, P. (2012). Everyday (in)justices and ordinary environmentalisms: community gardening in disadvantaged urban neighbourhoods. Local Environment, 17(9), 943-957. doi:10.1080/13549839.2011.607158
Milburn, L. A. S., & Vail, B. A. (2010). Sowing the seeds of success: Cultivating a future for community gardens. Landscape Journal, 29(1), 71-89.
Miles, R., & Song, Y. A. N. (2009). "Good" Neighborhoods in Portland, Oregon: Focus on both social and physical environments. Journal of Urban Affairs, 31(4), 491-509. doi:10.1111/j.1467-9906.2009.00457.x
Miller, N. E., & Dollard, J. (1941). Social learning and imitation: Yale University Press New Haven.
Milligan, C., Gatrell, A., & Bingley, A. (2004). 'Cultivating health': therapeutic landscapes and older people in northern England. Social Science & Medicine, 58(9), 1781-1793. doi:10.1016/s0277-9536(03)00397-6
Milligan, C., Payne, S., Bingley, A., & Cockshott, Z. (2015). Place and wellbeing: shedding light on activity interventions for older men. Ageing & Society, 35(1), 124-149. doi:10.1017/s0144686x13000494
Ministry for Culture and Heritage. (2014). Māori and European population numbers 1838–1901. Retrieved 2 April 2017 https://nzhistory.govt.nz/media/photo/maori-and-european-population-numbers
Ministry of Heallth. (2017). New Zealand health system. Retrieved from http://www.health.govt.nz/new-zealand-health-system
Ministry of Health. (2000). The New Zealand Public Health and Disability Act 2000. Retrieved from http://www.legislation.govt.nz/act/public/2000/0091/latest/DLM80051.html.
Ministry of Health. (2002). He Korowai Oranga Maori Health Strategy. Wellington: Ministry of Health.
Ministry of Health. (2003). Healthy Eating – Healthy Action, Oranga Kai – Oranga Pumau, A background 2003. Wellington: Ministry of Health, Retrieved from http://www.moh.govt.nz/healthlyeatinghealthyaction.
Ministry of Health. (2013). Health loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006-2016. Retrieved from Wellington: www.health.govt.nz
Ministry of Health. (2016). Annual Update of Key Results 2015/16: New Zealand Health Survey. (6521). Wellington: Ministry of Health.
Mitrou, F., Cooke, M., Lawrence, D., Povah, D., Mobilia, E., Guimond, E., & Zubrick, S. R. (2014). Gaps in Indigenous disadvantage not closing: A census cohort study of social determinants of health in Australia, Canada, and New Zealand from 1981-2006. Bmc Public Health, 14(1).
Mittelmark, M. B. (2014). Unintended effects in settings-based health promotion. Scandinavian journal of public health, 42(15 suppl), 17-24.
Mittelmark, M. B., Kickbusch, I., Rootman, I., Scriven, A., & Tones, K. (2008). Health Promotion. In H. Editor-in-Chief: Kris (Ed.), International Encyclopedia of Public Health (pp. 225-240). Oxford: Academic Press.

Moeke-Pickering, T. (1996). Maori identity within whanau: A review of literature. In.
Moeke-Pickering, T., Heitia, M., Heitia, S., Karapu, R., & Cote-Meek, S. (2015). Understanding Maori Food Security and Food Sovereignty Issues in Whakatane. MAI Journal, 4(1), 29-42.
Mohatt, N. V., Fok, C. C. T., Burket, R., Henry, D., & Allen, J. (2011). Assessment of Awareness of Connectedness as a Culturally-Based Protective Factor for Alaska Native Youth. Cultural Diversity & Ethnic Minority Psychology, 17(4), 444-455. doi:10.1037/a0025456
Monaghan, L. F., Colls, R., & Evans, B. (2013). Obesity discourse and fat politics: research, critique and interventions. Critical Public Health, 23(3), 249-262. doi:10.1080/09581596.2013.814312
Montgomery, K. S., & Schubart, K. J. (2010). Health promotion in culturally diverse and vulnerable populations. Home Health Care Management and Practice, 22(2), 131-139.
Moon, P. (2002). Te ara ki te Tiriti: The path to the Treaty of Waitangi. New Zealand: David Ling.
Moon, P. (2009). A chequered renaissance: The evolution of Maori society, 1984-2004. Te Kaharoa, 2(1).
Moyle, P. (2014). A model for Maori research for Maori practitioners. Aotearoa New Zealand Social Work, 26(1), 29.
Mules, R. (2010). Māra Kai: Gardening and community well-being. (Master of Arts), The University of Auckland, Auckland.
MUMA. (2014). Manukau Urban Maori Authority. Retrieved from http://www.muma.co.nz/
Mundel, E., & Chapman, G. E. (2010). A decolonizing approach to health promotion in Canada: The case of the Urban Aboriginal Community kitchen garden project. Health Promotion International, 25(2), 166-173.
Muriwai, E., Houkamau, C. A., & Sibley, C. G. (2015). Culture as Cure? The Protective Function of Māori Cultural Efficacy on Psychological Distress. New Zealand Journal of Psychology, 44(2), 14-24.
Mutu, M. (2010). Constitutional Intentions: The Treaty Texts. In M. Mulholland & V. Tawhai (Eds.), Weeping waters: The treaty of Waitangi and constitutional change (pp. 13-40). Wellington: Huia Publishers.
Naylor, L. (2012). Hired gardens and the question of transgression: lawns, food gardens and the business of 'alternative' food practice. Cultural Geographies, 19(4), 483-504. doi:10.1177/1474474012451543
Neff, R. A., Palmer, A. M., McKenzie, S. E., & Lawrence, R. S. (2009). Food Systems and Public Health Disparities. Journal of Hunger & Environmental Nutrition, 4(3-4), 282-314. doi:10.1080/19320240903337041
Nelson, A., Abbott, R., & Macdonald, D. (2010). Indigenous Australians and physical activity: using a social–ecological model to review the literature. Health Education Research, 25(3), 498-509. doi:10.1093/her/cyq025
Neo, H., & Chua, C. Y. (2017). Beyond Inclusion and Exclusion: Community Gardens as Spaces of Responsibility. Annals of the American Association of Geographers, 1-16. doi:10.1080/24694452.2016.1261687
Nesdole, R., Voigts, D., Lepnurm, R., & Roberts, R. (2014). Reconceptualizing determinants of health: Barriers to improving the health status of First Nations peoples. Can J Public Health, 105(3), 209-213.
Nettle, C., Catney, D. P., & Doyle, P. T. (2014). Community Gardening as Social Action. Farnham, UNKNOWN: Taylor and Francis.
Netto, G., Bhopal, R., Lederle, N., Khatoon, J., & Jackson, A. (2010). How can health promotion interventions be adapted for minority ethnic communities? Five principles for guiding the development of behavioural interventions. Health Promotion International, 25(2), 248-257.
New Zealand Government. (2013). Crown and Ngāi Tūhoe sign deed of settlement Press Release. Retrieved from www.beehive.govt.nz
Newman, L., Baum, F., Javanparast, S., O'Rourke, K., & Carlon, L. (2015). Addressing social determinants of health inequities through settings: a rapid review. Health Promotion International, 30(suppl_2), ii126-ii143. doi:10.1093/heapro/dav054
Ngā Pae o te Māramatanga. (2012). Rangahau. Retrieved from http://www.rangahau.co.nz
Ngai Tūhoe. (2014). Tūhoe Settlement. Retrieved from http://www.ngaituhoe.iwi.nz/
Ngati Whatua Orakei. (2014). Ngati Whatua Orakei. Retrieved from http://www.ngatiwhatuaorakei.com/ngati-whatua-orakei/
Nichols, J., Schutte, N. S., Brown, R. F., Dennis, C. L., & Price, I. (2009). The Impact of a Self-Efficacy Intervention on Short-Term Breast-Feeding Outcomes. Health Education & Behavior, 36(2), 250-258. doi:10.1177/1090198107303362
Nichter, M., Padmajam, S., Nichter, M., Sairu, P., Aswathy, S., Mini, G. K., . . . Thankappan, K. R. (2015). Developing a smoke free homes initiative in Kerala, India Health behavior, health promotion and society. Bmc Public Health, 15(1). doi:10.1186/s12889-015-1815-1
Northrop, M. D., Wingo, B. C., & Ard, J. D. (2013). The perceptions of community gardeners at Jones Valley Urban farm and the implications for dietary interventions. Qualitative Report, 18(27).
O'Sullivan, D. (2008). The Treaty of Waitangi in Contemporary New Zealand Politics. Australian Journal of Political Science, 43(2), 317-331. doi:10.1080/10361140802035804
O'Hara, L., Taylor, J., & Barnes, M. (2016). The invisibilization of health promotion in Australian public health initiatives. Health Promotion International, daw051.
Ogawa, T. (2009). Looking at community gardens through neoliberal lenses. (Master of Science), Iowa State University, Retrieved from http://lib.dr.iastate.edu/etd/11125
Ohmer, M. L., Meadowcroft, P., Freed, K., & Lewis, E. (2009). Community Gardening and Community Development: Individual, Social and Community Benefits of a Community Conservation Program. Journal of Community Practice, 17(4), 377-399. doi:10.1080/10705420903299961
Okvat, H. A., & Zautra, A. J. (2011). Community Gardening: A Parsimonious Path to Individual, Community, and Environmental Resilience. American Journal of Community Psychology, 47(3-4), 374-387.

Oliver, L., Wood, M., Frawley, C., Almond, J., & Larkins, S. (2015). Retrospective audit of postnatal attendance for Aboriginal and Torres Strait Islander women attending a community-controlled health service in north Queensland. Australian Family Physician, 44(4), 243.
Orange, C. (2011). The Treaty of Waitangi: Bridget Williams Books.
Orbach, A. (2011). Rethinking participation, rethinking power: reflections on local autonomy. Canadian Journal of Development Studies-Revue Canadienne D Etudes Du Developpement, 32(2), 196-209. doi:10.1080/02255189.2011.596033
Orji, R. (2016). Persuasion and Culture: Individualism–Collectivism and Susceptibility to Influence Strategies. Paper presented at the Proceedings of the International Workshop on Personalization in Persuasive Technology (PPT'16), Salzburg, Austria.
Pajares, F. (2002). Overview of social cognitive theory and of self-efficacy. Retrieved from http://www.emory.edu/EDUCATION/mfp/eff.html
Pajares, F., Prestin, A., Chen, J., & Nabi, R. L. (2009). Social cognitive theory and media effects: na.
Palmater, P. (2011). Beyond blood: Rethinking indigenous identity: UBC Press.
Panaretto, K. S., Wenitong, M., Button, S., & Ring, I. T. (2014). Aboriginal community controlled health services: leading the way in primary care. Med J Aust, 200(11), 649-652.
Paradies, Y. (2016). Colonisation, racism and indigenous health. Journal of Population Research, 33(1), 83-96.
Payyappallimana, U. (2010). Role of Traditional Medicine in Primary Health Care: An Overview of Perspectives and Challenging. Yokohama Journal of Social Sciences, 14(6).
Pearce, S., & Pickard, H. (2013). How therapeutic communities work: Specific factors related to positive outcome. International Journal of Social Psychiatry, 59(7), 636-645. doi:10.1177/0020764012450992
Pearson, D. H., & Firth, C. (2012). Diversity in community gardens: Evidence from one region in the United Kingdom. Biological Agriculture and Horticulture, 28(3), 147-155.
Penetito, W. (2011). Kaupapa Māori education: Research as the exposed edge. Paper presented at the Kei Tua o Te Pae Hui Proceedings - The Challenges of Kaupapa Māori Research in the 21st century, Wellington.
Perkins, H. A. (2009). Out from the (Green) shadow? Neoliberal hegemony through the market logic of shared urban environmental governance. Political Geography, 28(7), 395-405. doi:http://dx.doi.org/10.1016/j.polgeo.2009.09.007
Perkins, H. A. (2010). Green spaces of self-interest within shared urban governance. Geography Compass, 4(3), 255-268.
Perriam, G. (2015). Sacred spaces, healing places: therapeutic landscapes of spiritual significance. The Journal of medical humanities, 36(1). doi:10.1007/s10912-014-9318-0
Peterson, M. (2016). Living with difference in hyper-diverse areas: how important are encounters in semi-public spaces? Social & Cultural Geography, 1-19.
Phillips, J. (2015). History of immigration - A growing settlement: 1825 to 1839. In Te Ara - the Encyclopedia of New Zealand (Ed.). www.TeAra.govt.nz.
Phillips, S. M., & McAuley, E. (2013). Physical activity and quality of life in breast cancer survivors: The role of self-efficacy and health status. Psycho-Oncology.
Pholi, K., Black, D., & Richards, C. (2009). Is 'Close the Gap'a useful approach to improving the health and wellbeing of Indigenous Australians? Australian Review of Public Affairs, 9(2), 1-13.
Pihama, L. (2011, 5-6 May 2011). A conversation about Kaupapa Māori theory and research. Paper presented at the Kei Tua o Te Pae Hui Proceedings - The Challenges of Kaupapa Māori Research in the 21st century, Wellington.
Pihama, L., Cram, F., & Walker, S. (2002). Kaupapa Maori Principles and Practices - A literature review. Retrieved from Auckland:
Pinto, B. M., & Ciccolo, J. T. (2011). Physical Activity Motivation and Cancer Survivorship. In K. S. Courneya & C. M. Friedenreich (Eds.), Physical Activity and Cancer (pp. 367-387). Berlin, Heidelberg: Springer Berlin Heidelberg.
Pitt, H. (2014). Therapeutic experiences of community gardens: putting flow in its place. Health & Place, 27(0), 84-91. doi:http://dx.doi.org/10.1016/j.healthplace.2014.02.006
Place, J. (2012). The health of Aboriginal people residing in urban areas. Canada: National Collaborating Centre for Aboriginal Health Prince George, BC.
Pleschberger, K. (2014). Urban Gardening in European Cities.
Poata-Smith, E. (2004). Ka tika a muri, Ka tika a mua? -Māori Protest Activities and the Treaty of Waitangi Settlement Process. In P. Spooney, C. Macpherson, & D. George (Eds.), Tangata Tangata: The Changing Ethnic Contours of New Zealand (pp. 59-88). Southbank Victoria: Thomson Dunmore Press.
Poland, B., & Dooris, M. (2010). A green and healthy future: the settings approach to building health, equity and sustainability. Critical Public Health, 20(3), 281-298. doi:10.1080/09581596.2010.502931
Poland, B., Krupa, G., & McCall, D. (2009). Settings for health promotion: an analytic framework to guide intervention design and implementation. Health PRomotion Practice, 10(4), 505-516.
Pool, I. (2015). Colonization and Development in New Zealand between 1769 and 1900 (Vol. 3). Hamilton: Springer Internationa;.
Porsanger, J. (2004). An essay about indigenous methodology. Nordlit, 8(1), 105-120.
Poulsen, M. N., Hulland, K. R. S., Gulas, C. A., Pham, H., Dalglish, S. L., Wilkinson, R. K., & Winch, P. J. (2014). Growing an Urban Oasis: A Qualitative Study of the Perceived Benefits of Community Gardening in Baltimore, Maryland. Culture, Agriculture, Food and Environment, 36(2), 69-82. doi:10.1111/cuag.12035
Power, J., Grealy, C., & Rintoul, D. (2009). Tobacco interventions for Indigenous Australians: a review of current evidence. Health Promotion Journal of Australia, 20(3), 186-194.

Priest, N., Mackean, T., Davis, E., Briggs, L., & Waters, E. (2012). Aboriginal perspectives of child health and wellbeing in an urban setting: Developing a conceptual framework. Health Sociology Review, 21(2), 180-195.
Pudup, M. B. (2008). It takes a garden: Cultivating citizen-subjects in organized garden projects. Geoforum, 39(3), 1228-1240. doi:10.1016/j.geoforum.2007.06.012
Pulvirenti, M., McMillan, J., & Lawn, S. (2014). Empowerment, patient centred care and self-management. Health Expectations, 17(3), 303-310. doi:10.1111/j.1369-7625.2011.00757.x
Pyett, P.-C. P. d. S. A. (2008). Challenging our own practices in Indigenous health promotion and research. Health Promotion Journal of Australia, 19(3), 179-183.
Quinn, D. M., & Chaudoir, S. R. (2009). Living with a concealable stigmatized identity: the impact of anticipated stigma, centrality, salience, and cultural stigma on psychological distress and health. Journal of Personality and Social Psychology, 97(4), 634.
Ralston, C. (1993). Maori Women and the Politics of Tradition: What Roles and Power Did, Do, and Should Maori Women Exercise? The Contemporary Pacific, 23-44.
Rankin, B. H., & Quane, J. M. (2002). Social Contexts and Urban Adolescent Outcomes: The Interrelated Effects of Neighborhoods, Families, and Peers on African-American Youth. Social Problems, 49(1), 79-100. doi:10.1525/sp.2002.49.1.79
Ratima, M. (2001). Kia uruuru mai a hauora - Being Healthy, Being Māori, Conceptualising Māori Health Promotion. (Doctor of Philosophy), University of Otago, Dunedin.
Ratima, M. (2010). Maori health promotion - a comprehensive definition and strategic considerations. Retrieved from Health Promotion Forum of New Zealand website: http://www.hpforum.org.nz
Reading, C. L., & Wien, F. (2009). Health inequalities and the social determinants of Aboriginal peoples' health: National Collaborating Centre for Aboriginal Health Prince George, BC.
Redmond, B. F. (2012). Fall 2012 Self-Efficacy Case Study. Retrieved from https://wikispaces.psu.edu/display/PSYCH484/Fall+2012+Self-Efficacy+Case+Study
Redvers, J. M. (2016). Land-based Practice for Indigenous Health and Wellness in Yukon, Nunavut, and the Northwest Territories. (Environment Design Masters), University of Calgary, Alberta.
Reid, J., Taylor-Moore, K., & Varona, G. (2013). Towards a Social-Structural Model for Understanding Current Disparities in Maori Health and Wellbeing. Journal of Loss and Trauma.
Reid, P., & Robson, B. (2006). The state of Māori health. In M. Mulholland (Ed.), State of the Maori Nation: Twenty-first Century Issues in Aotearoa. Auckland: Reed Books.
Reilly, R. E., Cincotta, M., Doyle, J., Firebrace, B. R., Cargo, M., van den Tol, G., . . . Heart Hlth Project Steering, C. (2011). A pilot study of Aboriginal health promotion from an ecological perspective. Bmc Public Health, 11. doi:749 10.1186/1471-2458-11-749
Renwick, W. L. (1990). The treaty now: GP Books.
Reznikova, K. V., Zamaraeva, J. S., Kistova, A. V., & Pimenova, N. N. (2014). The current state of traditional socio-cultural practices of indigenous peoples of the North (on the example of cultures of Selkups, Nenets and Essey Yakuts). Life Sci J, 11(12), 126.
Ricciardelli, L. A., Mellor, D., McCabe, M. P., Mussap, A. J., Hallford, D. J., & Tyler, M. (2012). Promoting fit bodies, healthy eating and physical activity among Indigenous Australian men: a study protocol. Bmc Public Health, 12. doi:28 10.1186/1471-2458-12-28
Richard, L., Gauvin, L., & Raine, K. (2011). Ecological models revisited: their uses and evolution in health promotion over two decades. Annual review of public health, 32, 307-326.
Richmond, C. A. M., & Cook, C. (2016). Creating conditions for Canadian aboriginal health equity: the promise of healthy public policy. Public Health Reviews, 37(1), 2. doi:10.1186/s40985-016-0016-5
Ristovski-Slijepcevic, S., Bell, K., Chapman, G. E., & Beagan, B. L. (2010). Being 'thick' indicates you are eating, you are healthy and you have an attractive body shape: Perspectives on fatness and food choice amongst Black and White men and women in Canada. Health Sociology Review, 19(3), 317-329. doi:10.5172/hesr.2010.19.3.317
Ritenburg, H. (2014). Embodying Decolonization - Methodologies and indigenization. AlterNative, 10(1), 67-80.
Robson, B., & Ellison-Loschmann, L. (2016). Māori and cancer care in Aotearoa/New Zealand – responses to disparities. European Journal of Cancer Care, 25(2), 214-218. doi:10.1111/ecc.12472
Robson, J. J. P., & Troutman-Jordan, M. L. (2015). Back to Basics: Health and Wellness Benefits of Gardening in Older Adults. Activities, Adaptation & Aging, 39(4), 291-306. doi:10.1080/01924788.2015.1089709
Rocha, C., & Liberato, R. S. (2013). Food sovereignty for cultural food security: the case of an indigenous community in Brazil. Food, Culture & Society, 16(4), 589-602.
Roos, S. M., Potgieter, J. C., & Temane, M. Q. (2013). Self-Efficacy, Collective Efficacy and the Psychological Well-Being of Groups in Transition. Journal of Psychology in Africa, 23(4), 561-567. doi:10.1080/14330237.2013.10820668
Rose, E. (2012). Encountering place: A psychoanalytic approach for understanding how therapeutic landscapes benefit health and wellbeing. Health & Place, 18(6), 1381-1387. doi:http://dx.doi.org/10.1016/j.healthplace.2012.07.002
Roskruge, N. (2011). Traditional Māori horticultural and ethnopedological praxis in the New Zealand landscape. Management of Environmental Quality: An International Journal, 22(2), 200-212.
Rosol, M. (2010). Public Participation in Post-Fordist Urban Green Space Governance: The Case of Community Gardens in Berlin. International Journal of Urban and Regional Research, 34(3), 548-563. doi:10.1111/j.1468-2427.2010.00968.x
Rosol, M. (2012). Grassroots gardening initiatives: Community gardens in Berlin. Advances in Ecopolitics, 9, 123-143.

Rotheram-Borus, M. J., Swendeman, D., & Chovnick, G. (2009). The Past, Present, and Future of HIV Prevention: Integrating Behavioral, Biomedical, and Structural Intervention Strategies for the Next Generation of HIV Prevention. Annual review of clinical psychology, 5, 143-167. doi:10.1146/annurev.clinpsy.032408.153530
Rudolph, K. R., & McLachlan, S. M. (2013). Seeking Indigenous food sovereignty: Origins of and responses to the food crisis in northern Manitoba, Canada. Local Environment, 18(9), 1079-1098.
Ryks, J., Howden-Chapman, P., Robson, B., Stuart, K., & Waa, A. (2014). Maori participation in urban development: challenges and opportunities for indigenous people in Aotearoa New Zealand. Lincoln Planning Review, 6(1-2), 4-17.
Sabone, M. B. (2009). The Promotion of Mental Health Through Cultural Values, Institutions, and Practices: A Reflection on Some Aspects of Botswana Culture. Issues in Mental Health Nursing, 30(12), 777-787. doi:10.3109/01612840903263579
Salmond, A. (2012). Ontological quarrels: Indigeneity, exclusion and citizenship in a relational world. Anthropological Theory, 12(2), 115-141.
Sampson, R., & Gifford, S. M. (2010). Place-making, settlement and well-being: The therapeutic landscapes of recently arrived youth with refugee backgrounds. Health & Place, 16(1), 116-131.
Sampson, R. J. (2003). Collective Efficacy. In K. Christensen & D. Levinson (Eds.), Encyclopedia of Community: From the Village to the Virtual World: Sage Publications.
Sampson, R. J., & Graif, C. (2009). Neighborhood Social Capital as Differential Social Organization Resident and Leadership Dimensions. American Behavioral Scientist, 52(11), 1579-1605. doi:10.1177/0002764209331527
Sampson, R. J., Raudenbush, S. W., & Earls, F. (1997). Neighborhoods and Violent Crime: A Multilevel Study of Collective Efficacy. Science, 277(5328), 918-924. doi:10.1126/science.277.5328.918
Samson, A., & Solmon, M. (2011). Examining the sources of self-efficacy for physical activity within the sport and exercise domains. International Review of Sport and Exercise Psychology, 4(1), 70-89. doi:10.1080/1750984x.2011.564643
Sanchez, E. L., & Liamputtong, P. (2017). Community gardening and health-related benefits for a rural Victorian town. Leisure Studies, 36(2), 269-281. doi:10.1080/02614367.2016.1250805
Sarche, M., Tafoya, G., Croy, C. D., & Hill, K. (2017). American Indian and Alaska Native boys: Early childhood risk and resilience amidst context and culture. Infant Mental Health Journal, 38(1), 115-127.
Sarin, J., Hunt, J., Ivers, R. G., & Smyth, C. (2015). Lifting the burden: a coordinated approach to action on Aboriginal tobacco resistance and control in NSW. Public Health Research & Practice, 25(3).
Sasakamoose, J., Scerbe, A., Wenaus, I., & Scandrett, A. (2016). First Nation and Metis Youth Perspectives of Health: An Indigenous Qualitative Inquiry. Qualitative Inquiry, 22(8), 636-650. doi:10.1177/1077800416629695
Savin-Baden, M., & Major, C. (2013). Qualitative Research: The Essential Guide to Theory and Practice. Abingon, UK,: Routledge.
Schiff, J. W., & Moore, K. (2006). The impact of the sweat lodge ceremony on dimensions of well-being. American Indian and Alaska Native Mental Health Research, 13(3), 48-69.
Schoen, D., Balchin, D., & Thompson, S. (2010). Health promotion resources for Aboriginal people: lessons learned from consultation and evaluation of diabetes foot care resources. Health Promotion Journal of Australia, 21(1), 64-69.
Schunk, D. H., & Pajares, F. (2009). Self-Efficacy Theory. In K. Wentzel & A. Wigfield (Eds.), Handbook of Motivation at School. New York: Routledge.
Schunk, D. H., & Pajares, F. (2010). Self-Efficacy Beliefs. In P. Peterson, E. Baker, & B. McGaw (Eds.), International Encyclopedia of Education (Third Edition) (pp. 668-672). Oxford: Elsevier.
Schwarzer, R., & Fuchs, R. (1996). Self-efficacy and health behaviours. Predicting health behaviour: Research and practice with social cognition models, 163-196.
Schwarzer, R., & McAuley, E. (2016). The world is confounded: a comment on Williams and Rhodes (2016). Health Psychology Review, 10(2), 133-135. doi:10.1080/17437199.2016.1162667
Schweigman, K., Soto, C., Wright, S., & Unger, J. (2011). The relevance of cultural activities in Ethnic Identity among California Native American youth. Journal of Psychoactive Drugs, 43(4), 343-348.
Sebastian, T., & Donelly, M. (2013). Policy influences affecting the food practices of indigenous Australians since colonisation. Australian Aboriginal Studies(2), 59-75.
Shareck, M., Frohlich, K. L., & Poland, B. (2013). Reducing social inequities in health through settings-related interventions — a conceptual framework. Global Health Promotion, 20(2), 39-52. doi:doi:10.1177/1757975913486686
Sharples, P. (2009). Launch of Maara Kai Programme. Retrieved from www.beehive.govt.nz/speech/launch+maara+kai+programme
Sherwood, J. (2010). Do no harm: decolonising Aboriginal health research. (Doctor of Philosophy Doctorate), University of New South Wales,
Shin, H., Shin, J., Liu, P. Y., Dutton, G. R., Abood, D. A., & Ilich, J. Z. (2011). Self-efficacy improves weight loss in overweight/obese postmenopausal women during a 6-month weight loss intervention. Nutrition Research, 31(11), 822-828. doi:10.1016/j.nutres.2011.09.022
Sibley, C. G., & Houkamau, C. A. (2013). The multi-dimensional model of maori identity and cultural engagement: Item response theory analysis of scale properties. Cultural Diversity and Ethnic Minority Psychology, 19(1), 97-110.
Singer, J., Putulik Kidlapik, C., Martin, B., Dean, H., Trepman, E., & Embil, J. (2014). Food consumption, obesity and abnormal glycaemic control in a Canadian Inuit community. Clinical obesity, 4(6), 316-323.

Skinner, K., Pratley, E., & Burnett, K. (2016). Eating in the City: A Review of the Literature on Food Insecurity and Indigenous People Living in Urban Spaces. Societies, 6(2), 7.
Smedslund, J. (1978). Some psychological theories are not empirical: Reply to Bandura. Scandinavian Journal of Psychology, 19(1), 101-102. doi:10.1111/j.1467-9450.1978.tb00309.x
Smith, G. (1997). The development of kaupapa Māori: theory and praxis. (Doctoral), University of Auckland,
Smith, G., Hoskins, T. K., & Jones, A. (2012). Interview: Kaupapa Māori: The dangers of domestication. New Zealand Journal of Educational Studies, 47(2), 10.
Smith, L. (1999). Decolonizing Methodologies: research and indigenous peoples. London: University of Otago Press.
Smith, L. (2012). Decolonizing methodologies: research and indigenous peoples London: Zed Books.
Smith, L. (2014). Social Justice, Transformation and Indigenous Methodologies. In E. R. Rinehart, N. K. Barbour, & C. C. Pope (Eds.), Ethnographic Worldviews: Transformations and Social Justice (pp. 15-20). Dordrecht: Springer Netherlands.
Smylie, J., Kirst, M., McShane, K., Firestone, M., Wolfe, S., & O'Campo, P. (2016). Understanding the role of Indigenous community participation in Indigenous prenatal and infant-toddler health promotion programs in Canada: A realist review. Social Science & Medicine, 150, 128-143. doi:http://dx.doi.org/10.1016/j.socscimed.2015.12.019
Snijder, M., Shakeshaft, A., Wagemakers, A., Stephens, A., & Calabria, B. (2015). A systematic review of studies evaluating Australian indigenous community development projects: the extent of community participation, their methodological quality and their outcomes. Bmc Public Health, 15(1), 1154.
Snow, K. C., Hays, D. G., Caliwagan, G., Ford, D. J., Mariotti, D., Mwendwa, J. M., & Scott, W. E. (2015). Guiding principles for indigenous research practices. Action Research. doi:10.1177/1476750315622542
Snyder, M., & Wilson, K. (2015). “Too much moving… there's always a reason”: Understanding urban Aboriginal peoples' experiences of mobility and its impact on holistic health. Health & Place, 34, 181-189.
Socha, T., Zahaf, M., Chambers, L., Abraham, R., & Fiddler, T. (2012). Food security in a northern First Nations community: an exploratory study on food availability and accessibility. International Journal of Indigenous Health, 8(2), 5.
Stajkovic, A. D., Lee, D., & Nyberg, A. J. (2009). Collective Efficacy, Group Potency, and Group Performance: Meta-Analyses of Their Relationships, and Test of a Mediation Model. Journal of Applied Psychology, 94(3), 814-828. doi:10.1037/a0015659
Stang, J. (2009). Improving Health among American Indians through Environmentally-Focused Nutrition Interventions. Journal of the American Dietetic Association, 109(9), 1528-1531. doi:http://dx.doi.org/10.1016/j.jada.2009.06.371
Statistics New Zealand. (1997). Long-term data series 1858-1996. Retrieved from www.stats.govt.nz
Statistics New Zealand. (2006a). QuickStats About Maori. Retrieved from www.stats.govt.nz
Statistics New Zealand. (2006c). QuickStats about Auckland City. Retrieved from www.stats.govt.nz
Statistics New Zealand. (2011). Estimated resident population of New Zealand. Retrieved from http://www.stats.govt.nz
Statistics New Zealand. (2013a). QuickStats about Māori. Retrieved from www.stats.govt.nz.
Statistics New Zealand. (2013b). New Zealand census totals by topics. Retrieved from www.stats.govt.nz
Stewart, J. M. (2015). A multi-level approach for promoting HIV testing within African American church settings. AIDS patient care and STDs, 29(2), 69-76.
Stewart, J. M., Sanon-Fisher, R. W., Eades, S., & Fitzgerald, M. (2012). The risk status, screening history and health concerns of Aboriginal and Torres Strait Islander people attending an Aboriginal Community Controlled Health Service. Drug and Alcohol Review, 31(5), 617-624.
Stoner, L., Page, R., Matheson, A., Tarrant, M., Stoner, K., Rubin, D., & Perry, L. (2015). The indigenous health gap: raising awareness and changing attitudes. Perspectives in Public Health, 135(2), 68-70. doi:10.1177/1757913915569965
Stronik, M. L., Nelson, C. H., & McLaren, B. (2010). The Learning Garden: Place-based Learning for Holistic First Nations’ Community Health Retrieved from Canadian Council on Learning: http://www.ccl-cca.ca/pdfs/FundedResearch/Stroink-LearningGardenFullReport.pdf
Stuart, J., & Jose, P. E. (2014). The protective influence of family connectedness, ethnic identity, and ethnic engagement for New Zealand Maori adolescents. Developmental Psychology, 50(6), 1817-1826.
Taitimu, M. (2007). Maori ways of understanding extra-ordinary experiences and schizophrenia. (Doctor of Philosophy), The University of Auckland, Auckland. Retrieved from https://researchspace.auckland.ac.nz/bitstream/handle/2292/3367/02whole.pdf?sequence=7
Tam, B. Y., Findlay, L., & Kohen, D. (2014). Social networks as a coping strategy for food insecurity and hunger for young Aboriginal and Canadian children. Societies, 4(3), 463-476.
Tangihaere, T. M., & Twiname, L. (2011). Providing space for indigenous knowledge. Journal of Management Education, 35(1), 102-118.
Tapsell, P. (2002). Marae and Tribal Identity in Urban Aotearoa/New Zealand. Pacific Studies, 25(1-2), 141-171.
Tapsell, P. (2014). Tribal marae: Crisis? What Crisis? In M. Kawharu (Ed.), Maranga Mai! Te Reo and marae in crisis? (pp. 35-63). Auckland: Auckland University Press.
Tapsell, P. (2017). The marae and its place. Profiles. Retrieved from http://www.otago.ac.nz/profiles/themaraeanditsplace.html
Tasa, K., Taggar, S., & Seijts, G. H. (2007). The development of collective efficacy in teams: A multilevel and longitudinal perspective. Journal of Applied Psychology, 92(1), 17-27. doi:10.1037/0021-9010.92.1.17
Taskforce on Whānau-Centred Initiatives. (2009). Whānau Ora: Report of the Taskforce on Whānau-Centred Initiatives. Retrieved from New Zealand: https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/planning-strategy/whanau-ora/whanau-ora-taskforce-report.pdf

Te Hiwi, E. (2008, 23-24 November). Disrupted Spaces: Racism and the lived experience of Maori identity formation. Paper presented at the Claiming Spaces: Proceedings of the 2007 National Maori and Pacific Psychologies Symposium,, Hamilton, New Zealand.
Te Potiki National Trust. (2017). Māori Maps. Retrieved from http://www.maorimaps.com
Te Puni Kokiri. (2012). Whānau Ora - Fact Sheet. In Te Puni Kokiri (Ed.). Wellington: Te Puni Kokiri,.
Te Puni Kōkiri. (1995). Health through the Marae. Te Whanganui-a-Tara: Te Puni Kōkiri.
Te Puni Kōkiri. (2001). He Tirohanga o Kawa ki te Tiriti o Waitangi: A Guide to the principles of the Treaty of Waitangi as expressed by the Courts and the Waitangi Tribunal. Wellington: Online Retrieved from http://www.tpk.govt.nz/en/in-print/our-publications/publications/he-tirohanga-o-kawa-ki-te-tiriti-o-waitangi/.
Te Puni Kōkiri. (2009). Hauora Maori - Maori Health. Fact Sheet: 011-2009. Retrieved from Te Puni Kokiri website: http://www.tpk.govt.nz/en/in-print/our-publications/fact-sheets/maori-health/download/tpk-maorihealth-2009-en.pdf
Te Puni Kōkiri. (2010). Tamaki Makaurau Marae Directory. Retrieved from http://www.maraedirectory.com
Te Puni Kōkiri. (2012a). Whānau Ora - Fact Sheet. In Te Puni Kōkiri (Ed.). Wellington: Te Puni Kokiri,.
Te Puni Kōkiri. (2012b). Flourishing Māra kai. Kōkiri 26 2012. Retrieved from Te Puni Kōkiri website: http://www.tpk.govt.nz/en/in-print/kokiri/kokiri-26-2012/flourishing-mara-kai/
Te Puni Kōkiri. (2012c). Whānau Social Assistance programmes. Retrieved from http://www.tpk.govt.nz/en/in-print/kokiri/kokiri-27-2012/whanau-social-assistance-programmes/
Te Puni Kōkiri. (2012d). The Status Of Marae in 2009. Retrieved from Wellington: https://www.tpk.govt.nz/en/a-matou-mohiotanga/marae-development
Teig, E., Amulya, J., Bardwell, L., Buchenau, M., Marshall, J. A., & Litt, J. S. (2009). Collective efficacy in Denver, Colorado: strengthening neighborhoods and health through community gardens. Health & Place, 15(4), 1115-1122.
Tengland, P.-A. (2016). Behavior Change or Empowerment: On the Ethics of Health-Promotion Goals. Health Care Analysis, 24(1), 24-46. doi:10.1007/s10728-013-0265-0
Theodore, R., McLean, R., & TeMorenga, L. (2015). Challenges to addressing obesity for Māori in Aotearoa/New Zealand. Australian and New Zealand Journal of Public Health, 39(6), 509-512.
Thompson, L., & Kumar, A. (2011). Responses to health promotion campaigns: Resistance, denial and othering. Critical Public Health, 21(1), 105-117.
Thompson, S., Gulrukh, A., Ballard, M., Beardy, B., Islam, D., Lozeznik, V., & Wong, K. (2011). Is community economic development putting healthy food on the table? Food sovereignty in North Manitoba's Aboriginal Communities. Journal of Aboriginal Economic Development, 7(2), 14-39.
Thompson, S., Kamal, A. G., Alam, M. A., & Wiebe, J. (2012). Community development to feed the family in northern Manitoba communities: evaluating food activities based on their food sovereignty, food security, and sustainable livelihood outcomes. Canadian journal of nonprofit and social economy research, 3(2), 43.
Thompson, S. C., Haynes, E., Shahid, S., Woods, J. A., Teng, T.-H. K., Davidson, P. M., & Davidson, P. M. (2015). Shedding light or fanning flames?: a consideration of the challenges in exploring the relative effectiveness of Aboriginal Community Controlled Health Services. Quality in Primary Care, 23(3), 141-149.
Thompson, S. L., Chenhall, R. D., & Brimblecombe, J. K. (2013). Indigenous perspectives on active living in remote Australia: A qualitative exploration of the socio-cultural link between health, the environment and economics. Bmc Public Health, 13(1).
Timu-Parata, C. (2009). May the Dreams of the Past Be the Reality of the Future: Reflections on the Maori Health Journey. Whitireia Nursing & Health Journal(16), 38.
Tipene-Leach, D. C., Coppell, K. J., Abel, S., Pahau, H. L. R., Ehau, T., & Mann, J. I. (2013). Ngāti and healthy: translating diabetes prevention evidence into community action. Ethnicity and Health.
Tobias, J. K. (2015). "We are the Land": Researching Environmental Repossession with Anishinaabe Elders. (Doctor of Philosophy), The University of Western Ontario, Retrieved from http://ir.lib.uwo.ca/etd/2784/
Tobias, J. K., & Richmond, C. A. M. (2014). “That land means everything to us as Anishinaabe….”: Environmental dispossession and resilience on the North Shore of Lake Superior. Health & Place, 29(0), 26-33.
Toi, F. (2014). Auē, Taukiri ē: The changing face of marae. In M. Kawharu (Ed.), Maranga Mai! Te Reo and marae in crisis? (pp. 129-137). Auckland: Auckland University Press.
Tomlins Jahnke, H. (2011). Colonial Theories of the State: Maori/State relations. In H. Tomlins Jahnke & M. Mulholland (Eds.), Mana Tangata - Politics of Empowerment (pp. 13-43). Wellington: Huia Publishers.
Torp, S., Kokko, S., & Ringsberg, K. C. (2014a). Promoting health in everyday settings: Opportunities and challenges. In: Sage Publications Sage UK: London, England.
Torp, S., & Vinje, H. F. (2014b). Is workplace health promotion research in the Nordic countries really on the right track? Scandinavian Journal of Social Medicine, 42(15_suppl), 74-81.
Tountas, Y. (2009). The historical origins of the basic concepts of health promotion and education: the role of ancient Greek philosophy and medicine. Health Promotion International. doi:10.1093/heapro/dap006
Triandis, H. C. (1995). Individualism & collectivism: Westview Press.
Trickett, E., & Beehler, S. (2013). The Ecology of Multilevel Interventions to Reduce Social Inequalities in Health. American Behavioral Scientist, 57(8), 1227-1246. doi:doi:10.1177/0002764213487342
Tse, S., Laverack, G., Nayar, S., & Foroughian, S. (2011). Community engagement for health promotion: Reducing injuries among Chinese people in New Zealand. Health Education Journal, 70(1), 76-83. doi:10.1177/0017896909349241

Tsey, K., Whiteside, M., Haswell-Elkins, M., Bainbridge, R., Cadet-James, Y., & Wilson, A. (2010). Empowerment and Indigenous Australian health: A synthesis of findings from family wellbeing formative research. Health and Social Care in the Community, 18(2), 169-179.
Turia, T. (2010). Whanau Ora about empowering families. Retrieved from http://tvnz.co.nz/politics-news/whanau-ora-empowering-families-3446810
Turner, B. (2011). Embodied connections: Sustainability, food systems and community gardens. Local Environment, 16(6), 509-522.
Turner, B., Henryks, J., & Pearson, D. (2011). Community gardens: Sustainability, health and inclusion in the city. Local Environment, 16(6), 489-492.
UBC Farms. (2014). Indigenous Initiatives. Retrieved from http://ubcfarm.ubc.ca/community/indigenous-initiatives/
Uchida, C. D., Swatt, M. L., Solomon, S. E., & Varano, S. (2014). Neighborhoods and crime: collective efficacy and social cohesion in Miami-Dade county. National Institute of Justice Report.
United Nations. (2011). Population Distribution, Urbanization, Internal Migration and Development: An International Perspective (ESA/P/WP/223). Retrieved from http://www.un.org/esa/population/publications/PopDistribUrbanization/PopulationDistributionUrbanization.pdf
Upton, S. (1991). Your health and the public health: a statement of government health policy. Wellington: GP Print Ltd.
Usborne, E., & Taylor, D. M. (2010). The role of cultural identity clarity for self-concept clarity, self-esteem, and subjective well-being. Personality and Social Psychology Bulletin, 36(7), 883-897.
Van Meijl, T. (2015). Ownership and Distribution in the Settlement of Maori Grievances: Balancing Historical and Social Justice Between Classes. In F. McCormack & K. Barclay (Eds.), Engaging with Capitalism: Cases from Oceania (Vol. 33, pp. 29-52): Emerald Group Publishing.
Veen, E. J., Bock, B. B., Van den Berg, W., Visser, A. J., & Wiskerke, J. S. C. (2016). Community gardening and social cohesion: different designs, different motivations. Local Environment, 21(10), 1271-1287. doi:10.1080/13549839.2015.1101433
Velasquez, A., & LaRose, R. (2015). Youth collective activism through social media: The role of collective efficacy. New Media & Society, 17(6), 899-918. doi:10.1177/1461444813518391
Viriaere, H. H. M. (2015). He taonga tuku iho te whakarite kaupapa mō ngā māra kai tuturu - Living indigenous heritage: planning for Māori gardens. (Masters), Massey University, Massey University, Palmerston North, New Zealand.
Wagemakers, A., Vaandrager, L., Koelen, M. A., Saan, H., & Leeuwis, C. (2010). Community health promotion: A framework to facilitate and evaluate supportive social environments for health. Evaluation and Program Planning, 33(4), 428-435. doi:10.1016/j.evalprogplan.2009.12.008
Waitangi Tribunal. (2011). Ko Aotearoa Tenei - A Report into Claims Concerning New Zealand Law and Policy Affecting Māori Culture and Identity. Wellington: Legislation Direct Retrieved from www.waitangitribunal.govt.nz.
Waka Maori. (2014). Orakei Marae. Maori Culture. Retrieved from http://www.wakamaori.co.nz/maori-culture/marae/orakei-marae/
Wakefield, S., Yeudall, F., Taron, C., Reynolds, J., & Skinner, A. (2007). Growing urban health: Community gardening in South-East Toronto. Health Promotion International, 22(2), 92-101. doi:10.1093/heapro/dam001
Walker, R. (1975). Marae: A Place to Stand. In M. King (Ed.), Te Ao Hurihuri: The World Moves On. Wellington: Hicks Smith.
Walker, R. (1989). The Urban Maori. In Te Kaunihera Whakakaupapa mo Aotearoa (Ed.), He Matapuna - Some Maori Perspectives. Wellington: Government Printer. (Reprinted from: 1989).
Walker, R. (1992). Marae: A place to stand. In M. King (Ed.), Te Ao Hurihuri - Aspects of Māoritanga. Auckland: Reed Books.
Walker, R., Schultz, C., & Sonn, C. (2014). Cultural competence–Transforming policy, services, programs and practice. Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice, 195-220.
Walker, S., Eketone, A., & Gibbs, A. (2006). An exploration of kaupapa Maori research, its principles, processes and applications. International Journal of Social Research Methodology, 9(4), 331-344. doi:10.1080/13645570600916049
Walsh, M. L. (2014). Substance abuse prevention in American Indian and Alaska Native communities: Exploration of guiding theoretical underpinnings and theoretical fit in practice. (Doctor of Philosophy), University of South Florida,
Walter, P. (2012). Theorising community gardens as pedagogical sites in the food movement. Environmental Education Research, 19(4), 521-539. doi:10.1080/13504622.2012.709824
Walters, K. L., Beltran, R., Huh, D., & Evans-Campbell, T. (2011). Dis-placement and Dis-ease: Land, Place, and Health Among American Indians and Alaska Natives. New York: Springer.
Walters, K. L., Spencer, M. S., Smukler, M., Allen, H. L., Andrews, C., Browne, T., . . . Uehara, E. (2016). Eradicating Health Inequalities for Future Generations.
Wang, M., & Hu, X. (2011). An agent-based model for simulating collective efficacy.
Warner, L. M., Schüz, B., Knittle, K., Ziegelmann, J. P., & Wurm, S. (2011). Sources of perceived self-efficacy as predictors of physical activity in older adults. Applied Psychology: Health and Well-Being, 3(2), 172-192.
Warr, D., Feldman, P., Tacticos, T., & Kelaher, M. (2009). Sources of stress in impoverished neighbourhoods: insights into links between neighbourhood environments and health. Australian and New Zealand Journal of Public Health, 33(1), 25-33. doi:10.1111/j.1753-6405.2009.00334.x

Waterworth, P. (2015). Factors Affecting West Australian Indigenous Community Members' Health Behaviour. (Doctor of Philosophy), The University of Western Australia, Australia.
Waterworth, P., Rosenberg, M., Braham, R., Pescud, M., & Dimmock, J. (2014). The effect of social support on the health of Indigenous Australians in a metropolitan community. Social Science & Medicine, 119, 139-146. doi:10.1016/j.socscimed.2014.08.035
Watson, J. B. (1913). Psychology as the behaviorist views it. Psychological Review, 20(2), 158-177. doi:10.1037/h0074428
Watson, M. R. (2006). A journey of Indigenous identity. Medical Journal of Australia, 185(3), 150-151.
Watzlawik, M. (2012). Cultural identity markers and identity as a whole: Some alternative solutions. Culture & Psychology, 18(2), 253-260. doi:10.1177/1354067x11434843
Waziyatawin. (2005). Decolonizing Indigenous diets. In W. Wilson & M. Bird (Eds.), For Indigenous eyes only: A decolonization handbook (pp. 67-86). Santa Fe: School of American Research Press.
Weaver, H. N., & Heartz, M. Y. H. B. (1999). Examining Two Facets of American Indian Identity: Exposure to Other Cultures and the Influence of Historical Trauma. Journal of Human Behavior in the Social Environment, 2(1-2), 19-33. doi:10.1300/J137v02n01_03
Weiner-Levy, N., & Queder, S. A. R. (2012). Researching my people, researching the "other": field experiences of two researchers along shifting positionalities. Quality & Quantity, 46(4), 1151-1166. doi:10.1007/s11135-012-9677-4
Wen Li, W., Hodgetts, D., & Ho, E. (2010). Gardens, Transitions and Identity Reconstruction among Older Chinese Immigrants to New Zealand. Journal of Health Psychology, 15(5), 786-796. doi:10.1177/1359105310368179
Wen, M., Browning, C. R., & Cagney, K. A. (2003). Poverty, affluence, and income inequality: neighborhood economic structure and its implications for health. Social Science & Medicine, 57(5), 843-860. doi:http://dx.doi.org/10.1016/S0277-9536(02)00457-4
Wendt, D., & Gone, J. P. (2012a). Urban-Indigenous Therapeutic Landscapes: A Case Study of an Urban American Indian Health Organization Health & Place(June).
Wendt, D., & Gone, J. P. (2012b). Rethinking cultural competence: Insights from indigenous community treatment settings. Transcultural Psychiatry, 49(2), 206-222. doi:10.1177/1363461511425622
Wexler, L. (2009a). The Importance of Identity, History, and Culture in the Wellbeing of Indigenous Youth. The Journal of the History of Childhood and Youth, 2(2), 267-276.
Wexler, L. (2014a). Looking across three generations of Alaska Natives to explore how culture fosters indigenous resilience. Transcultural Psychiatry, 51(1), 73-92.
Wexler, L., DiFluvio, G., & Burke, T. K. (2009b). Resilience and marginalized youth: Making a case for personal and collective meaning-making as part of resilience research in public health. Social Science & Medicine, 69(4), 565-570. doi:http://dx.doi.org/10.1016/j.socscimed.2009.06.022
Wexler, L., Joule, L., Garoutte, J., Mazziotti, J., & Hopper, K. (2014b). "Being responsible, respectful, trying to keep the tradition alive:" Cultural resilience and growing up in an Alaska Native community. Transcultural Psychiatry, 51(5), 693-712. doi:10.1177/1363461513495085
Wham, C., Maxted, E., Dyall, L., Teh, R., & Kerse, N. (2012). Korero te kai o te Rangatira: Nutritional wellbeing of Maori at the pinnacle of life. Nutrition & Dietetics, 69(3), 213-216.
Whiteside, M., Tsey, K., & Earles, W. (2011). Locating Empowerment in the Context of Indigenous Australia. Australian Social Work, 64(1), 113-129. doi:10.1080/0312407x.2010.533279
Whitinui, P. (2011). The Treaty and "treating" Maori health: Politics, policy and partnership. AlterNative, 7(2), 138-151.
WHO. (1986). World Health Organisation - Ottawa Charter for Health Promotion. Paper presented at the An International Conference on Health Promotion, WHO Regional Office for Europe, Copenhagen, Denmark.
Wickes, R., Hipp, J. R., Sargeant, E., & Homel, R. (2013). Collective Efficacy as a Task Specific Process: Examining the Relationship Between Social Ties, Neighborhood Cohesion and the Capacity to Respond to Violence, Delinquency and Civic Problems. American Journal of Community Psychology, 52(1-2), 115-127. doi:10.1007/s10464-013-9582-6
Wickes, R. L. (2010). Generating Action and Responding to Local Issues Collective Efficacy in Context. Australian and New Zealand Journal of Criminology, 43(3), 423-443. doi:10.1375/acri.43.3.423
Wilk, P., & Cooke, M. (2015). Collaborative Public Health System Interventions for Chronic Disease Prevention Among Urban Aboriginal Peoples. The International Indigenous Policy Journal, 6(4), 1-14.
Williams, A. M. (2009). Therapeutic landscapes as health promoting places. United Kingdom: Blackwell Publishing Limited.
Williams, A. M. (2010). Therapeutic Landscapes as Health Promoting Places. In A companion to health and medical geography (pp. 205-223): Wiley-Blackwell.
Williams, D. M., & Rhodes, R. E. (2016). The confounded self-efficacy construct: conceptual analysis and recommendations for future research. Health Psychology Review, 10(2), 113-128. doi:10.1080/17437199.2014.941998
Williams, D. R., & Mohammed, S. A. (2013). Racism and Health I: Pathways and Scientific Evidence. American Behavioral Scientist, 57(8), 1152-1173.
Williams, E., Guenther, J., & Arnott, A. (2011). Traditional healing: a literature review. Working paper series 2: Evaluation and policy, 2. Retrieved from Covaluator Network website: http://www.covaluator.net/docs/S2.2_traditional_healing_lit_review.pdf
Williamson, A., Redman, S., Dadds, M., Daniels, J., D'Este, C., Raphael, B., . . . Skinner, T. (2010). Acceptability of an emotional and behavioural screening tool for children in Aboriginal Community Controlled Health Services in urban NSW. Australian and New Zealand Journal of Psychiatry, 44(10), 894-900.

Willows, N. D., Hanley, A. J. G., & Delormier, T. (2012). A socioecological framework to understand weight-related issues in Aboriginal children in Canada. Applied Physiology, Nutrition, and Metabolism, 37(1), 1-13. doi:10.1139/h11-128
Wills, J., Chinemana, F., & Rudolph, M. (2010). Growing or connecting? An urban food garden in Johannesburg. Health Promotion International, 25(1), 33-41. doi:10.1093/heapro/dap042
Wilson, A. D. (2013). Beyond Alternative: Exploring the Potential for Autonomous Food Spaces. Antipode, 45(3), 719-737. doi:10.1111/j.1467-8330.2012.01020.x
Wilson, J. (2016). European discovery of New Zealand - Abel Tasman. In Te Ara - the Encyclopedia of New Zealand (Ed.). www.TeAra.govt.nz.
Wilson, K. (2003). Therapeutic landscapes and First Nations peoples: an exploration of culture, health and place. Health & Place, 9(2), 83-93. doi:10.1016/s1353-8292(02)00016-3
Wilson, K., & Richmond, C. (2009). Indigenous Health and Medicine. In K. Rob & T. Nigel (Eds.), International Encyclopedia of Human Geography (pp. 365-370). Oxford: Elsevier.
Wilson, K., Rosenberg, M. W., & Abonyi, S. (2011). Aboriginal peoples, health and healing approaches: The effects of age and place on health. Social Science & Medicine, 72(3), 355-364. doi:10.1016/j.socscimed.2010.09.022
Wilson, S. (2008). Research is ceremony: Indigenous research methods. Canada: Fenwood Publishing.
Wingo, B. C., Desmond, R. A., Brantley, P., Appel, L., Svetkey, L., Stevens, V. J., & Ard, J. D. (2013). Self-efficacy as a Predictor of Weight Change and Behavior Change in the PREMIER Trial. Journal of Nutrition Education and Behavior(0). doi:http://dx.doi.org/10.1016/j.jneb.2012.12.004
Wirihana, R., & Smith, C. (2014). Historical trauma, healing and well-being in Maori communities. MAI Review, 3(3), 198-210.
Wood, L., France, K., Hunt, K., Eades, S., & Slack-Smith, L. (2008). Indigenous women and smoking during pregnancy: Knowledge, cultural contexts and barriers to cessation. Social Science & Medicine, 66(11), 2378-2389. doi:http://dx.doi.org/10.1016/j.socscimed.2008.01.024
Wu, D. S., Hu, J., McCoy, T. P., & Efird, J. T. (2014). The effects of a breastfeeding self-efficacy intervention on short-term breastfeeding outcomes among primiparous mothers in Wuhan, China. Journal of Advanced Nursing, 70(8), 1867-1879. doi:10.1111/jan.12349
Yamanis, T. J., Maman, S., Mbwambo, J. K., Earp, J. A. E., & Kajula, L. J. (2010). Social venues that protect against and promote HIV risk for young men in Dar es Salaam, Tanzania. Social Science & Medicine, 71(9), 1601-1609. doi:http://dx.doi.org/10.1016/j.socscimed.2010.07.039
Yarwood, V. (2005). Abel Tasman - The search for Terra Australis Incognita and the discovery of Zeelandia Novia. New Zealand Geographic, Mar-Apr 2005(072).
Yon, Y., & Crimmins, E. M. (2014). Cohort morbidity hypothesis: Health inequalities of older Maori and non-Maori in New Zealand. New Zealand Population Review, 40, 63.
Zaccaro, S. J., Blair, V., Peterson, C., & Zazanis, M. (1995). Collective Efficacy. In J. E. Maddux (Ed.), Self-Efficacy, Adaptation, and Adjustment: Theory, Research, and Application (pp. 305-328). Boston, MA: Springer US.
Zhu, Y. S. (2015). Toward community engagement: Can the built environment help? Grassroots participation and communal space in Chinese urban communities. Habitat International, 46, 44-53. doi:10.1016/j.habitatint.2014.10.013
Ziabakhsh, S., Pederson, A., Prodan-Bhalla, N., Middagh, D., & Jinkerson-Brass, S. (2016). Women-Centered and Culturally Responsive Heart Health Promotion Among Indigenous Women in Canada. Health PRomotion Practice, 17(6), 814-826. doi:doi:10.1177/1524839916633238