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Ngā Kaupapa Wawata me Uara: A narrative review exploring Tiriti o Waitangi-centred population health programmes in Aotearoa New Zealand

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Article abstract

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Ngā Kaupapa Wawata me Uara: A Narrative Review Exploring Tiriti o Waitangi-Centred Population Health Programmes in Aotearoa New Zealand

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Abstract

Globally, Indigenous Peoples experience widespread health inequities. Treaties provide a potential framework to uphold Indigenous rights and progress health equity. Te Tiriti o Waitangi (Māori language version of the Treaty of Waitangi) established the relationship between Māori, the Indigenous people of Aotearoa (New Zealand), and the British Crown. Grounded in Kaupapa Māori theory, this literature review used an Indigeneity-Grounded Analysis (IGA) policy lens to identify four characteristics of Tiriti-centred population health programmes: whanaungatanga (relationships), pro-equity actions, Te Ao Māori (Māori worldviews), and accountability. Although the evidence-base is emergent, a rights-based approach identifies the centrality of Indigenous self-determination, structural and system transformation, and freedom from discrimination. Indigenous knowledge provides the foundation for treaty-centered policy supportive of Indigenous rights and health equity.

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Background

Similar to Indigenous Peoples around the world, Māori, the Indigenous Peoples of Aotearoa, continue to experience persistent and pervasive health inequities (Anderson et al., 2016; Ministry of Health, 2015). These unfair and unjust differences in health are characterised by differential access to determinants of health and health services, and differences in the quality of care received (Jones, 2001). Underpinning these pathways is the relationship between racism and coloniality (Reid et al., 2019). Racism, a complex system leading to the inequitable distribution of power by 'race' (Paradies, 2006), operates at many levels. Structural racism encompasses the macrolevel social, institutional and ideological processes and policies that generate and maintain ethnic inequities (Gee & Ford, 2011), and has the most fundamental impact on health (Jones, 2000). Also known as institutional racism, Jones describes "differential access to the goods, services, and opportunities of society by race" (Jones, 2000, p. 1212), identifying inaction in the face of need as a common manifestation.

In recent years, equity, pursuing the highest standard of health for all people (Braveman, 2014), and Māori health equity have received increasing political and public policy attention in Aotearoa (Ministry of Health, 2022). However, despite this relative prominence in the policy agenda, significant contemporary health sector reports continue to describe an inequitable health system that is not sufficiently responsive to Māori and does not honour Te Tiriti o Waitangi (Health and Disability System Review, 2020; Health Quality & Safety Commission, 2019; Waitangi Tribunal, 2019).

Te Tiriti o Waitangi established the relationship between the British Crown and Māori in 1840. Application as a framework occurs in the context of two versions of the treaty—one in the Māori language (Te Tiriti), to which the majority of Rangatira (chiefs) signed, and one in English (the Treaty). Te Tiriti gives the Crown "te kāwanatanga" (governance) in Article One and guarantees "te tino rangatiratanga", the unqualified exercise of chieftainship over "whenua, kāinga and taonga katoa" (land, homes and villages, and all treasures/things of value) in Article Two. In comparison, the Treaty says that Māori cede sovereignty in Article One, whilst maintaining "exclusive and undisturbed possession" of their lands and estates, forests, fisheries and other properties in Article Two, giving the Crown greater power. The third article, generally considered a fair translation, affords Māori the Crown's protection and all the rights of British subjects in both versions.

Over the last 60 years, Tiriti/Treaty principles emerged as a way for the Crown to manage differences in translation. In 1975, the Waitangi Tribunal was established as a permanent Crown commission charged with investigating Treaty breaches and providing recommendations for government action. Tasked with giving weight to both Te Tiriti and the Treaty, the Tribunal developed a series of principles to capture the 'spirit' of the agreement (Waitangi Tribunal, 2022). The concept of applying principles in the Aotearoa public sector was popularised in the 1990s by what became known as the "three P's"—partnership, protection, and participation (Te Puni Kōkiri, 2001). The three P's largely dominated Treaty/Tiriti principles in health policy up until a 2019 Waitangi Tribunal report in which the primary healthcare system was recommended to adhere to the Waitangi Tribunal principles of tino rangatiratanga (self-determination), equity, active protection, options, and partnership (Waitangi Tribunal, 2019). Known commonly as the Hauora report

principles, these principles have informed contemporary health policy including the Ministry of Health's current Te Tiriti o Waitangi framework (Ministry of Health, 2020b).

Consistent with international treaty law, Māori have maintained that Te Tiriti, as opposed to the Treaty, sets out the constitutional relationship between the Crown and Māori. This position is affirmed by the Waitangi Tribunal finding that iwi (tribes) and hapū (sub-tribes) did not cede sovereignty in signing Te Tiriti (Waitangi Tribunal, 2014). In an Indigenous-led report on constitutional transformation, Matike Mai, Māori scholars and advocates describe a values-based framework that acknowledges the conditions preceding Te Tiriti, including the signing of He Whakaputanga (the Declaration of Independence), from 1835 to 1840 (Matike Mai Aotearoa, 2016). This report articulates a vision for the Māori-Crown relationship in terms of three spheres of influence: the "kāwanatanga sphere" whereby the government makes decisions for its peoples, the "rangatiratanga sphere" where Māori make decisions for Māori, and the "relational sphere" where Māori and the government work together as equals. Of note, the latter requires upholding of Māori self-determination and inclusion of Māori in decision-making arenas.

In this context, Te Tiriti provides a framework for a rights-based approach to Māori health gain and equity. A rights-based approach encompasses adoption of processes and ways that are shaped by and uphold human rights principles (Gruskin et al., 2010), specific to health is the right to the highest attainable standard of health (UNCHR & AFR, 2013; United Nations [General Assembly], 1966). Although application of the approach in health varies, core features include but are not limited to (i) the duty to respect, protect, and fulfil human rights; (ii) full and inclusive participation of key stakeholders and communities; (iii) non-discrimination; and (iv) government accountability to fulfil their human rights obligations (Gruskin et al., 2010; Hunt & Backman, 2008; Jones et al., 2014). Common to frameworks are universally recognised values and legal obligations (Hunt & Backman, 2008). As such, a rights-based approach is strengths-based, paying particular attention to the most marginalised whose rights are most threatened or have not been fully realised (Reid, 2011).

In order to develop a Tiriti-centred alcohol harm minimisation population health programme in the Counties Manukau region (south and east Auckland), Aotearoa Māori researchers at Te Kupenga Hauora Māori, Waipapa Taumata Rau, University of Auckland, mana whenua (Indigenous people with historical and territorial rights over land), and the Counties Manukau Alcohol Harm Minimisation Team (Crown, publicly-funded team in a district health entity) have partnered in research. This narrative review informed a broader research project and aimed to describe key characteristics of Tiriti o Waitangi-centred population health programmes using published literature, in particular describing characteristics of relevance to Indigenous rights and health equity.

Methods

This narrative review is positioned within Kaupapa Māori theory and practice, an approach that is grounded in Māori values, recognises the legitimacy and validity of Māori, and the ongoing struggle for autonomy (Smith, 1997). An adaptation of Ngā Poutama Whetū (NPW) (Wright, Dehar, et al., 2022; Wright, Tapera, et al., 2022), translated to stairway to the stars, provided the framework for this research. This culturally progressive approach privileges critical Indigenous and Māori perspectives to circumvent the mono-cultural non-Indigenous voice that saturates academic literature (Hapeta, 2019). Table 1 provides a summary of methods and research design.

Table 1. Summary of methods and research design

Aspect of method/research design	Description
Approach	Kaupapa Māori
Narrative review method	Ngā Poutama Whetū
Data source	Electronic research databases (Scopus, Embase [Ovid], Medline [Ovid], PubMed) AND Grey literature search (Google search engine to identify websites ending in govt.nz)
Search terms	Treaty/Tiriti, programme/service, population health, New Zealand
Kaupapa-aligned inclusion criteria	Use Tiriti/Treaty as a framework Describe a population health programme or service Describe features of a Tiriti/Treaty-centred programme 'By' and 'with' Māori; 'for' Māori reviewed on case-by-case basis
Kaupapa-aligned exclusion criteria	Deficit framing of Māori (i.e., focus on Māori as the problem; internal deficiencies identified as cause of disparities)
Data extraction domains	Description of population health programme Key Tiriti/Treaty framework elements Description of programme development process Relationships involved in programme Involvement of Māori in research (using the CONSIDER checklist)
Data analysis	Indigeneity-Grounded Analysis (IGA) policy lens Adaptation of Arnstein's ladder of participation to illustrate differential power and control in Māori-Crown relationships

Research design

The research team was led by Māori researchers (KW, RJ) and supported by a Māori research assistant (AD). These members of the research team determined the application of the approach (Kaupapa Māori) and methods (NPW) to ensure alignment with the kaupapa, the collective aims and aspirations. This study focused on the use of Te Tiriti o Waitangi/the Treaty of Waitangi as a framework for population health programme design. Diverse expressions of Tiriti/Treaty were included in the study, for example Tiriti articles, Tiriti/Treaty principles, and other relevant approaches (e.g., rights-based, values). Population health programmes were defined as the implementation of planned population health activities or services. Population health issues were inclusive of health outcomes, risk factors for health outcomes, or social determinants of health with a clear connection to health outcomes. Both original peer reviewed research and grey literature (i.e., publicly available reports) were considered as valid and legitimate knowledge for this study.

Data collection and analysis

An electronic research database search was completed between 28/09/21 and 06/10/21 for peer reviewed publications using selected databases (Scopus, Embase [Ovid], Medline [Ovid], PubMed). An electronic search was conducted on 01/10/21 for grey literature using Google search engine to identify websites ending in govt.nz. Systematic searching for non-governmental organisations (NGOs) was outside the scope of this study. Key stakeholders in alcohol harm

minimisation and Māori health equity research were approached to identify published examples of Tiriti/Treaty frameworks for population health programmes/services, particularly from NGOs. The reference lists of all full-read texts were searched for eligible literature. The same search terms (Tiriti, programme/service, population health, New Zealand), along with related specific terms (i.e., Treaty, Waitangi), were used for all database/search engine queries.

Articles and reports were appraised and evaluated with Kaupapa-aligned inclusion and exclusion criteria. Inclusion criteria included (i) using Tiriti/Treaty as a framework, (ii) describing a population health programme or service, (iii) describing features of a Tiriti/Treaty-centred programme, and (iv) research and programmes that were 'by' and 'with' Māori, meaning Māori either led the process or were actively involved. Research and programmes 'for' Māori, where Māori health gain was the focus but Māori were not active participants in the process, were reviewed on a case-by-case basis. Data that were deficit framing of Māori were excluded (i.e., focus on Māori as the problem (Reid & Robson, 2007); internal deficiencies identified as the cause of disparities such as ability, motivation, or behaviour (Valencia, 1997)). Titles and abstracts were screened by one researcher (AD) and audited by another (KW). Full texts were read in full by three researchers (AD, LS, KW).

Data were extracted by one researcher (AD) under six predetermined variables: description of population health programme, key Tiriti/Treaty framework elements, description of programme development process, relationships involved in programme development, relationships involved in programme, and involvement of Māori in research using the CONSIDER checklist (consolidated criteria for strengthening reporting of health research involving Indigenous peoples) to capture relationships involving Indigenous peoples in the research process (Huria et al., 2019). Data were coded and inter-related codes and overarching themes identified (AD and KW).

An Indigeneity-Grounded Analysis (IGA) policy lens was then applied to identify Tiriti characteristics of relevance to the right to health for Māori (AD and KW). Drawing on gender-based analysis frameworks, Fleras and Maaka (2010) describe a flexible and principle-based approach to analyse and assess impact of policy and programmes on Indigenous communities "within the context of 'power-sharing' 'partnership' and 'meaningful participation'" (p.21). Indigeneity principles of difference, rights, sovereignty, belonging, and spirituality inform appraisal of characteristics, providing a framework to minimise systematic policy bias and maximise the involvement of Indigenous peoples and perspectives. Arnstein's (1969) ladder of citizen participation was adapted to describe differential power and control in Māori-crown relationships (Table 2).

Table 2. Adapted ladder of citizen participation to illustrate differential power and control in Māori-Crown relationships

Degrees of citizen power	Control	Having full managerial power of a programme, including organisational, iwi, hapū or individual levels.
	Delegated power	Māori obtain the majority of decision-making seats.
	Partnership	Redistribution of power through negotiation between Māori and the Crown to achieve equal engagement as partners.
Degrees of tokenism	Placation	Māori groups and organisations having the ability to advise, with powerholders retaining the right to decide.
	Consultation	The invitation of Māori citizens to express their views and ideas without the assurance that they will be heard by powerholders.
	Informing	One-way relay of rights and responsibilities information from traditional powerholders to Māori citizens.
Non-participation	Therapy	To enable powerholders to "educate" and "cure" Māori.
	Manipulation	The positioning of Māori on advisory groups with the intention of educating others.

Results

A total of 1,260 texts were initially identified (365 from database search, 243 from grey literature search, and 652 from reference checks), with 1,137 being screened for eligibility after removal of duplicates, and 18 included for full text review. In total, five texts met the inclusion criteria for this narrative review, three grey literature reports and two peer-reviewed journal texts, published between 2019 and 2021 (Figure 1). The Ministry of Health published two of the reports and commissioned the third (Smith, 2020), a literature review prepared by an independent research unit. One Ministry of Health report, the Initial COVID-19 Māori Response Action Plan (Ministry of Health, 2020a), described a living document that was subsequently revised following stakeholder feedback. The updated version has been included in the review (Ministry of Health, 2020c).

Figure 1: PRISMA flow diagram
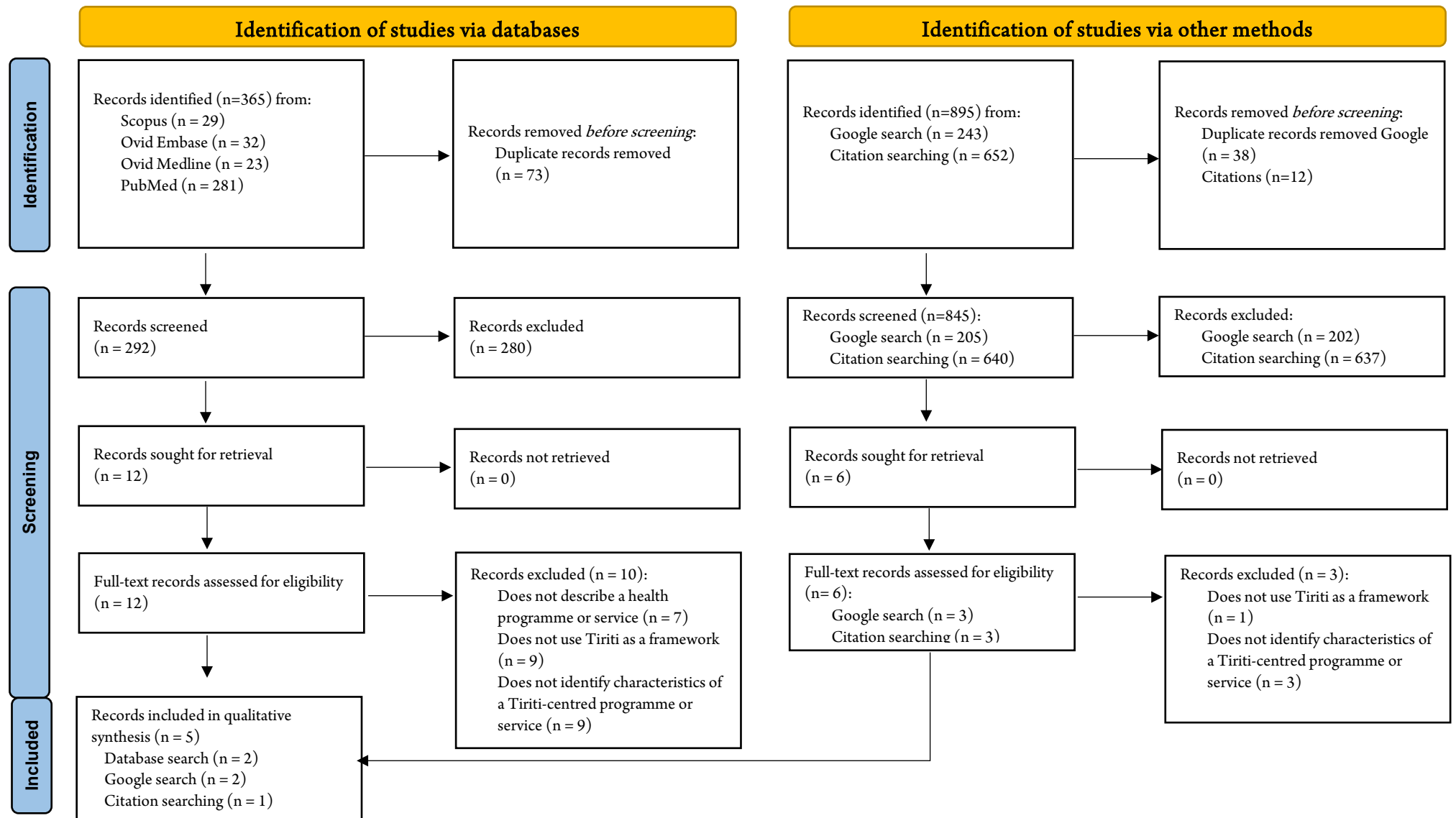
Included texts describe nationwide programmes across five public health issues: (i) homelessness (Lawson-Te Aho et al., 2019), (ii) national COVID-19 Māori response (Ministry of Health, 2020c) (iii) maternal-infant health (Stevenson et al., 2020), (iv) child health and wellbeing (Smith, 2020), and (v) COVID-19 vaccine and immunisation of Māori (Ministry of Health, 2021). Table 3 summarises the included texts.

Table 3. Author, literature type, programme, problem definition framing, Tiriti framework elements, and programme aims/objectives for included texts.

Author, year	Literature type	Programme	Problem definition framing	Tiriti framework elements	Programme aim/objective
Lawson-Te Aho et al., (2019)	Original research	Whare Ōranga (homelessness)	Health inequity Structural determinants Resilience	Tiriti articles Tiriti values	Māori health equity Māori rights Best practice
Ministry of Health (2020)	Report	Updated COVID-19 Māori Response Action Plan	Health inequity Social determinants	Tiriti articles Tiriti/Treaty principles	Māori health equity Māori rights Fulfil Tiriti obligations
Smith (2020)	Original research	Well Child Tamariki Ora (child health and wellbeing)	Health inequity Structural determinants Systems failure	Tiriti articles Tiriti/Treaty principles	Māori health equity Improve service performance and access Collaboration Culturally responsive
Stevenson et al., (2020)	Original research	Te Hā o Whānau (maternal-infant health)	Health inequity Systems failure Te Tiriti breach	Tiriti articles	Māori health equity Improve service performance and access Culturally responsive
Ministry of Health (2021)	Report	COVID-19 Vaccine and Immunisation Programme	Health inequity	Tiriti articles Tiriti/Treaty principles	Māori health equity Fulfil Tiriti obligations Improve service performance and access

Note. 'Problem definition framing' refers to how the situation or health issue was framed in the text.

All texts identified 'Health inequity' in problem definitions. Two texts went on to frame health issues and inequities in terms of healthcare system failure and Tiriti breaches (e.g., access and outcome health inequities) (Smith, 2020; Stevenson et al., 2020). Determinants of health were described (Ministry of Health, 2020c) and structural factors (i.e., social and economic policies) identified as shaping social determinants of health (Smith, 2020). Colonisation was identified as the root cause of inequities, resulting in historical and inter-generational trauma through land alienation and policy (Lawson-Te Aho et al., 2019; Smith, 2020). In one text, framing included resilience and a narrative of resistance and survival in an environment of traumatic oppression and disconnection (Lawson-Te Aho et al., 2019).

Whilst all programmes utilised Tiriti articles in some way, application varied. Programmes using the Ministry of Health Tiriti framework expressed Te Tiriti articles in mana terms, with mana being understood as prestige, authority, power and control (i.e., mana whakahaere/good government/Article One, mana motuhake/unique and Indigenous/Article Two, mana tangata/fairness and justice/Article Three, and mana Māori/cultural identity and integrity/declaration). Programme goals were articulated using the Hauora principles (Ministry of Health, 2020c, 2021). Lawson-Te Aho et al. (2019) articulated Tiriti values with regard to tino rangatiratanga and supporting Māori aspirations. Stevenson et al. (2020) aligned Tiriti articles with tikanga Māori (correct Māori procedure, custom and practice).

All programmes included 'Māori health equity' in aims and objectives. Māori rights-based aims included iwi self-determination (Lawson-Te Aho et al., 2019) and ensuring communities can exercise their authority to respond (Ministry of Health, 2020c). The Ministry of Health described fulfilling Tiriti obligations (Ministry of Health, 2021), including protecting Māori communities and ensuring equity responsibilities are met (Ministry of Health, 2020c). Service performance and access aims included increasing accessibility, improving system sustainability and performance, universal coverage, and ensuring value for money (Ministry of Health, 2021; Smith, 2020; Stevenson et al., 2020). Cultural responsiveness encompassed improving responsiveness, applying Māori principles (i.e., tikanga and Kaupapa Māori), and adopting a whānau-centred measurement framework (Lawson-Te Aho et al., 2019; Smith, 2020). Best practice aims specified drawing on international best practice models (Lawson-Te Aho et al., 2019), and collaboration was focussed on supporting intersectoral level relationships in order to address social determinants of health (Smith, 2020).

Features of Tiriti-centred population health programmes

Features of Tiriti-centred population health programmes are summarised in Table 4, being grouped under the four overarching themes described below:

1. Whanaungatanga (relationships): Encompassing relationships, connection through kinship, shared experience, and working together; this was a prominent characteristic of Tiriti-centred programmes.

2. Pro-equity actions: A broad range of strategies and actions (including resourcing and workforce) to address differential access to healthcare and support positive health outcomes.

3. Te Ao Māori (Māori worldviews): Māori worldviews comprises Kaupapa Māori research approaches and other applications of a Māori lens (Māori ways of being, knowing and doing), including actions based on tikanga principles, whānau-centred actions, and incorporating mātauranga Māori (knowledge embedded in Māori worldviews).

4. Accountability: The Crown and Crown agencies are responsible for addressing inequities and ensuring decisions, actions, services and programmes uphold Te Tiriti.

Table 4. Categorisation of Tiriti-centred population health programme features under key themes

Programme/text	Whanaungatanga (relationships)	Pro-equity actions	Te Ao Māori (Māori worldviews)	Accountability
Whare Ōranga (Lawson-Te Aho, 2019)	Māori-led research Māori involved in programme design Māori experts as partners Māori experts as advisors	Tino rangatiratanga based practice Culturally aligned practice	Utilise Māori lens Kaupapa Māori research	Crown oversight Crown obligation to uphold Te Tiriti Crown obligation to address inequities
Updated COVID-19 Māori Response Action Plan (Ministry of Health, 2020)	Māori organisations, groups and leaders as partners Māori advisory and monitoring groups Guidelines Health information Continuity of care	Fund providers, services, and communities Other resources for providers Workforce development Support Māori organisations Access to other services Equity surveillance and monitoring Targeted services Continuity of care and support	Utilise Māori lens Funding Kaupapa Māori approaches	Crown oversight Crown obligation to uphold Te Tiriti Crown commitment to address inequities
Well Child Tamariki Ora (Smith, 2020)	Māori leaders and community as partners	Workforce development Community-development Address structural racism Equitable funding Address social determinants Access to services Universally proportionate programme	Utilise Māori lens Kaupapa Māori research Mātauranga Māori data	Crown obligation to uphold Te Tiriti Crown commitment to address inequities
Te Hā o Whānau (Stevenson, 2020)	Māori-led research Māori experts as partners Māori experts as advisors	Workforce capacity development Address system injustice Uphold mana (prestige) Health literate organisation Standardise services Culturally responsive Targeted services	Respect and utilise Māori lens Kaupapa Māori research Mātauranga Māori data	Crown responsibility to uphold Te Tiriti
COVID-19 Māori Vaccine and Immunisation Programme (Ministry of Health, 2021)	Māori advisory and monitoring groups Health information	Funding providers Other resources for providers Workforce capacity development Options Best practice Equity surveillance and monitoring Ethnicity data collection Targeted services Community services	Kaupapa Māori practice	Crown obligation to uphold Te Tiriti Crown commitment to uphold Te Tiriti

Note: Māori lens refers to Māori ways of being, knowing and doing

An IGA policy lens has been applied to the features summarised in Table 4 to identify characteristics of relevance to Māori and Māori health gain. These are summarised in Table 5 and further described below under key themes.

Table 5. Categorisation of Tiriti-centred population health programme characteristics of relevance to Māori and Māori health gain

Whanaungatanga (relationships)	Pro-equity actions	Te Ao Māori (Māori worldviews)	Accountability
Māori-led research	Addressing structural and social determinants	Respect and utilise Māori lens	Crown responsibility to uphold Te Tiriti
Māori experts as partners (e.g., Māori organisations, communities, groups and leaders)	Systems level actions	Respect and utilise mātauranga Māori	Crown responsibility to address inequities
	Individual level actions		
	Resource and development	Fund and implement Kaupapa Māori research and practice	

Note: Māori lens refers to Māori ways of being, knowing and doing

1. Whanaungatanga

Arnstein's (1969) ladder of citizen participation was adapted to identify relationships in alignment with Indigeneity principles. The ladder assesses eight types of citizen participation across three levels: non-participation as (i) manipulation, and (ii) therapy; degrees of tokenism as (iii) informing, (iv) consultation, and (v) placation; and degrees of citizen power as (vi) partnership, (vii) delegated power, and (viii) citizen control. The ladder describes a continuum of levels of citizen participation and, although designed to be provocative, was not developed in the context of treaty relationships. As such, the typology has been adapted to illustrate differential power and control in Māori-Crown relationships (Table 2). Of note, programme relationships were often described in minimal detail, and we acknowledge that, although categorisation has been based on the descriptions available, actual relationships may differ from how they have been categorised.

Relationships demonstrating Māori having degrees of power (i.e., control, delegated power, and partnership) were considered to align with Indigenous rights and sovereignty and included as characteristics of a Tiriti-framework. Control, having full managerial power of a programme, could be at organisational, iwi, hapū, or individual levels. Māori control was presumed in Kaupapa Māori research related to programme development (Lawson-Te Aho et al., 2019; Stevenson et al., 2020) and was identified in one programme (Lawson-Te Aho et al., 2019). Māori 'governance' descriptions did not align with our definition when advisory based or framed in terms of encouraging Māori inclusion in governance roles, hence these relationships were not categorised as control. Partnership (i.e., the redistribution of power through negotiation between Māori and the Crown to achieve equal engagement as partners) was often challenging to confirm due to limited detail, but was suggested with iwi-based organisations (Ministry of Health, 2020c), Māori leaders and leadership groups (Ministry of Health, 2020c; Smith, 2020), and community and whānau (Smith, 2020). In Kaupapa Māori research used to inform programme development, interviews with diverse Māori experts were categorised as partnership with participants confirming and endorsing findings,

recognising that partnership may be limited to particular stages in the research process. Participants included Māori whānau (Lawson-Te Aho et al., 2019), kaumātua (elders, people of status within the whānau), health professionals, academics and researchers (Lawson-Te Aho et al., 2019; Stevenson et al., 2020), and activists (Stevenson et al., 2020). Relationships with iwi, Māori organisations (Ministry of Health, 2021), and Māori health professionals (Smith, 2020) were identified as being important, but the nature of the relationship was often unclear. Delegated power relationships (i.e., Māori obtain the majority of decision-making seats) were not identified.

Relationships demonstrating degrees of tokenism and non-participation were not included as characteristics central to a Tiriti-centred population health programme. Placation is defined by Māori groups and organisations having the ability to advise, with powerholders retaining the right to decide. This was identified in programme development (Lawson-Te Aho et al., 2019; Ministry of Health, 2020c, 2021; Stevenson et al., 2020) and the ongoing running and implementation of programmes (Ministry of Health, 2020c, 2021), being inclusive of Māori advisory groups and monitoring groups. Consultation, the invitation of Māori citizens to express their views and ideas without the assurance that they will be heard by powerholders, was not identified. Informing, one-way relay of rights and responsibilities information from traditional powerholders to Māori citizens, was identified in guidelines to help whānau prepare for self-isolation (Ministry of Health, 2020c). Therapy (i.e., to enable powerholders to "educate" and "cure" Māori) was identified in consumer health information (Ministry of Health, 2020c, 2021) and continuity of care and support packages (Ministry of Health, 2020c). Manipulation, the positioning of Māori on advisory groups with the intention of educating others, was not identified.

While this review was particularly interested in each programme's relationships with Māori whānau, iwi, hapū and other organisations, relationships between organisations within the health system and at intersectoral and interagency levels were also identified (e.g., Ministry of Social Development, Ministry of Housing and Urban development). Specific objectives of these relationships included addressing social determinants of health for Māori (Smith, 2020), providing community outreach services (Stevenson et al., 2020), supporting commissioning agencies, tailored communications, quality improvement, increasing access to medications, and providing care packages (Ministry of Health, 2020c).

2. Pro-equity actions

Addressing structural and social determinants, systems level actions, individual level actions, and resource and development were categorised as pro-equity actions (i.e., actions to support equitable health outcomes, including addressing differential access to and quality of healthcare). Actions addressing structural and social determinants included addressing existing epistemic injustice (i.e., respecting diverse worldviews and bodies of knowledge) and power imbalances in healthcare systems (Stevenson et al., 2020), addressing structural racism and inequitable funding (Smith, 2020), developing rights-based practices informed by Te Tiriti and tino rangatiratanga (Lawson-Te Aho et al., 2019), upholding mana (Stevenson et al., 2020), and supporting intersectoral collaboration to address social determinants for Māori (Smith, 2020).

Systems level actions were identified at service and organisation levels. Services need to be accessible (Ministry of Health, 2020c; Smith, 2020), culturally responsive (Lawson-Te Aho et al., 2019; Stevenson et al., 2020), and standardised (Stevenson et al., 2020), with an understanding that

services should respond to differential need (Smith, 2020) and provide options that are consistent with best practice (Ministry of Health, 2021). At an organisational level actions included Ministry-led surveillance and monitoring of actions and outcomes (Ministry of Health, 2020c, 2021), collecting iwi affiliation in ethnicity data collection (Ministry of Health, 2021), monitoring for best practice, developing a dedicated register, and monitoring services in Māori communities (Ministry of Health, 2020c, 2021). Being open to other knowledge systems and becoming a health literate healthcare system were identified as ways to recognise and alleviate epistemic injustice (Stevenson et al., 2020). At an individual level, actions included targeted services such as health services in high Māori population areas, tailored communications, and continuity of care for kaumātua (Ministry of Health, 2020c, 2021; Stevenson et al., 2020).

Resource and development actions included reorientating funding and other resources to support Māori providers, services and communities, specifically supporting providers and organisations through the provision of information, insights, and shared learning (Ministry of Health, 2020c, 2021). Workforce development actions were identified and inclusive of both capacity and capability building (Ministry of Health, 2020c, 2021; Smith, 2020; Stevenson et al., 2020), recognising that a diverse and representative workforce was necessary (Smith, 2020). Specific workforce capacity focused actions included increasing the capacity of the Māori healthcare workforce (e.g., reviewing education and training barriers, providing financial assistance to Māori providers, drawing on existing workforces with strong Māori representation including non-regulated health workforces, and supporting backfilling and additional workforce capacity arrangements) (Ministry of Health, 2020c, 2021; Stevenson et al., 2020), and supporting community-led initiatives (Ministry of Health, 2020c). Capability development was inclusive of community leadership (Ministry of Health, 2020c), strengthening whānau cultural connectedness and mātauranga Māori based solutions (Smith, 2020), and skills to support culturally appropriate care (e.g., cultural competence and cultural safety) (Ministry of Health, 2020c, 2021; Smith, 2020; Stevenson et al., 2020).

3. Te Ao Māori

All features categorised as Te Ao Māori aligned with Indigeneity principles and have been included as characteristics of a Tiriti-framework. Kaupapa Māori approaches included research (Lawson-Te Aho et al., 2019; Smith, 2020; Stevenson et al., 2020), evaluation (Smith, 2020) and practice (i.e., Kaupapa Māori vaccination training) (Ministry of Health, 2021), and the explicit recognition of funding for these approaches (Ministry of Health, 2020c). Other applications of a Māori lens (i.e., Māori ways of being, knowing and doing) included actions based on tikanga principles (Stevenson et al., 2020), a principles-lens on framework development (Lawson-Te Aho et al., 2019) and whānau-centred actions (i.e., measurement framework (Smith, 2020) and decision-making (Stevenson et al., 2020)). Importantly, there was recognition that Māori ways of being, knowing, and doing needed to be reclaimed, (Lawson-Te Aho et al., 2019), enabled (Smith, 2020) and respected (Stevenson et al., 2020). Mātauranga Māori data, knowledge embedded in Māori worldviews (Curtis, 2016), was inclusive of information sourced through discussions with Māori individuals, health experts, researchers and literature (Stevenson et al., 2020), and Māori methodologies and involvement in research (Smith, 2020; Stevenson et al., 2020).

4. Accountability

Accountability features included framing of both 'obligation' and 'responsibility' of which there are subtle but important differences in meaning and implication. Obligation infers a duty or often legally bound course of action that compels personal or organisational action. This was visible as meeting Tiriti obligations of protecting Māori rights and addressing inequities (Lawson-Te Aho et al., 2019; Ministry of Health, 2020c, 2021; Smith, 2020). Responsibility similarly infers a duty to act, however, includes accountability for actions under personal or organisational control. Examples include Crown responsibility to actively protect and reduce Māori: non-Māori inequities (Stevenson et al., 2020). Other language used in texts included 'commitment' to Te Tiriti and equity, and this was often paired with meeting Tiriti obligations (Ministry of Health, 2020c, 2021). Explicit consequences for not meeting obligations or responsibilities were not apparent. Responsibility framing was considered consistent with Indigeneity principles and was included as a characteristic of a Tiriti framework.

Discussion

This narrative review utilised a Kaupapa Māori approach to create an inventory of currently published Tiriti-centred population health programme characteristics of relevance to the right to health for Māori. Application of Indigeneity principles has supported the identification of characteristics addressing structural determinants and reflecting Indigenous perspectives. Grouped under four overarching themes (whanaungatanga, pro-equity actions, Te Ao Māori, and accountability), these characteristics can potentially support transformative practice and uphold Indigenous rights.

Te Tiriti o Waitangi provides the agreement from which the constitutional relationship between Māori and the Crown is defined, paving the way for co-existence and mutual benefit to both partners. As such, it is unsurprising that relationships were prominent features of Tiriti-centred population health programmes. However, not all relationships are equal, and a predominance of partnership and placation-based relationships were identified. In Aotearoa, Tiriti/Treaty 'partnerships' have often been performative and inconsistent with Māori self-determination and power sharing (Kukutai et al., 2020). Findings from our study suggest this may be an ongoing issue, with 'partnership' often referenced but infrequently clearly connected to decision-making and the assertion of tino rangatiratanga.

Understanding of tino rangatiratanga itself varies across population health programmes, extending from individualistic applications (i.e., enabling consumer choice, increasing consumer voice, and monitoring outcome) to collective understandings of iwi self-determination and authority. With this difference in expression comes considerable variation in the degree of Māori power and control at the governance level of programmes. Expressions of Māori self-determination apparent in population health programmes were often performative with power and control ultimately sitting with the Crown partner, a finding consistent with other critical Indigenous analysis (Baker et al., 2021). Self-determination is at the core of international Indigenous rights declarations and constitutional discussions with both political and cultural meaning (Asia Pacific Forum and the Office of the United Nations High Commissioner for Human Rights, 2013; Matike Mai Aotearoa, 2016). Māori understandings of power (mana) are inclusive of absolute authority, but also responsibility to hear and articulate the voice of the people, and to benefit future generations. This

links power and control with tikanga, understood to be both law and a set of values, and necessitates the meaningful integration of Māori ways of knowing and understanding in the expression of self-determination in policy (Matike Mai Aotearoa, 2016). In this regard, tino rangatiratanga, being inclusive of self-determination over ways of being, knowing and doing of significance to Indigenous communities (i.e., health systems and models of care), is a collective concept and much more than individual consumer choice (Jones, 2022; Reid et al., 2019). Policy and relationships maintaining coloniality and a racial hierarchy of participation and decision-making, perpetuate and maintain racist and inequitable health systems.

Addressing health inequities was consistently identified in problem definition framing and programme aims, suggesting centrality of equity and pro-equity actions in a Tiriti-based framework. However, although important, Reid (2013) reminds us that equity is a measure of good governance and is not synonymous with Te Tiriti. Kāwanatanga, the language used in Te Tiriti, acknowledges good governance as fair, just and ethical (Reid, 2011). As such, good governance is inclusive of Indigenous rights and the right to health and wellbeing. Most nations, including Aotearoa, have committed to the right to health, that is "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (United Nations [General Assembly], 1966, p. 4). An equitable health system is internationally recognised as a core social institution, however, the identification of right to health features of a health system remains emergent (Backman et al., 2008). The highest attainable standard of care, access to social determinants of health and appropriate services, and freedom from discrimination are recognised as key features in this evolving understanding (Backman et al., 2008).

Analysis of Tiriti-centred population health programmes has identified diverse pro-equity actions at individual, system and structural levels. Of note, culturally aligned models of care and targeted services/supports are consistent with the provision of accessible and appropriate services. However, it is important to recognise that without a comprehensive suite of interventions, inclusive of the social and structural determinants of health, they risk a more individual and 'needs-based' approach. The right to health provides a lens to identify actions central to Māori health gain and equity, for example, affirming Indigenous rights to self-determination, freedom from discrimination, and addressing structural racism. Racism is increasingly being recognised and identified in New Zealand government health and disability sector policy, yet explicit actions and plans remain scarce and often ineffective (Talamaivao et al., 2021), highlighting the need for organisational and multi-level solutions to see meaningful transformation.

The absence of clear accountability responsibilities and implications in Tiriti-centred population health programmes is concerning. Upholding the right to health requires government policy and actions to address healthcare services and broader social determinants of health (Reid, 2011), with accountability, specifically health system monitoring, evaluation, and adequate resourcing, being central to achieving equity (Chin et al., 2018). There are diverse understandings of accountability, however, in the context of health equity, it is inclusive of processes targeting systemic and structural drivers of health inequities, and specific to political and social context (Nelson et al., 2018). The Waitangi Tribunal Hauora report describes a permissive, semi-devolved health system resulting in a devolution of responsibility to address health inequities (Waitangi Tribunal, 2019). Without explicit consequences for failing to meet Tiriti obligations, Crown accountability is weak at best, and hapū and iwi excluded from being self-determining.

This research has many strengths. Utilising a Kaupapa Māori approach has privileged critical Indigenous and Māori perspectives, centring Indigenous rights and equity. Methods align with this approach, supporting structural analysis and transformative solutions. The systematic approach illustrates a robust process to identify Tiriti-centred population health programme characteristics using original peer reviewed research and publicly available government reports. However, it is recognised that due to the emergent nature of research in this area, the number of included texts is small and a limitation of this study. Furthermore, we recognise that unpublished programmes are excluded from this study, potentially limiting inclusion of programmes from community-based non-governmental organisations. In addition, the aim and descriptive nature of this review prevents analysis of the effectiveness of both included population health programmes and Tiriti-centred frameworks. The pro-equity actions identified were not evaluated in terms of ability to improve Māori health or achieve equity, being out of scope for this review, and this is recognised as an important area for future research. Finally, the inclusion of Tiriti-centred programmes only makes findings most relevant to Aotearoa, although general principles may be applicable to other countries.

Conclusions

Moana Jackson states that "to honour the treaty, we must first settle colonisation" (Mutu, 2019), highlighting the need for treaty-based frameworks to create space for healing, address structural racism, and develop solutions based on Indigenous knowledge and values. In the Aotearoa context, Te Tiriti defines a relationship grounded in Māori understandings of power and authority, identifying 'spheres of influence' in which both Māori and the Crown can exercise their authority. The characteristics of a Tiriti framework, therefore, should reflect the authentic application and understanding of Māori values and worldviews to envision the relationship described in Te Tiriti. Achieving this vision requires commitment to collective understandings of iwi self-determination and authority. Whilst this review contributes to building the evidence base, further work is needed to understand the characteristics of Tiriti-centred population health programmes and to understand relevance outside of Aotearoa. This requires the ongoing development and application of Indigenous-led rights-based frameworks to population health programmes, and the sharing of experience and expertise both within Aotearoa and with other settler colonial countries.

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Appendix A

Glossary

Aotearoa	New Zealand
Hapū	Kinship group, subtribe
Iwi	Extended kinship group, tribal area
Kaumātua	Elders, people of status within the whānau
Kaupapa	Collective aims and aspirations
Kāwanatanga	Good governance
Mana	Power and authority
Mana whenua	Customary owners, power associated with possession and occupation of tribal land
Mātauranga Māori	Knowledge embedded in Māori worldviews
Te Ao Māori	Māori world views
Tikanga	Correct Māori procedure, custom and practice
Tino rangatiratanga	Self-determination
Whānau	Extended family, family group
Whanaungatanga	Relationships through kinship and shared experiences

Abbreviations

IGA	Indigeneity grounded analysis
NPW	Ngā Poutama Whetū