

# CONCEPTUALISING THE LINK BETWEEN RESILIENCE AND WHĀNAU ORA

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## Results from a case study

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### Abstract

This paper addresses two objectives; first, to explore whether the concept of resilience, as described in the international literature, has resonance in the New Zealand Indigenous context; and second, to discuss the link between the concept of resilience and the Māori concept of whānau ora. The paper draws on findings from a qualitative study that utilised a single case study design. Data collection methods for the full study included a comprehensive literature review, organisational document review, conceptual framework development, in-depth key informant interviews and sequential focus groups with health service consumers. The utility, relevance and applicability of understandings of resilience in Māori health service provision are explored and discussed. Results affirm that an ecological perspective of resilience, while not necessarily articulated as such by individual case study participants, has some resonance with case study participants. We conclude that where Māori health providers are able to deliver health care using a whānau ora approach, specific to their unique community, such an approach can indeed support individual and whānau resilience.

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## Keywords

resilience, whānau ora, case study, primary health service, conceptual framework

## Background

In contemporary New Zealand, the impacts of colonisation, land loss, economic impoverishment and disenfranchisement continue to be manifest among many Māori whānau and community to this day. The persistent health inequalities that exist between Māori and non-Māori (Blakely, Tobias, & Atkinson, 2008; Robson & Harris, 2007) are a very clear example of these impacts. In recent decades there has been a recognition that if we, as a nation, are to address the “wicked” problem of Indigenous disadvantage (Head, 2008), a coordinated, collaborative approach across the multiple agencies of government and the multiplicity of government, community and whānau-based organisations and entities with a stake in enhancing Māori wellbeing is critical.

Whānau Ora,<sup>1</sup> described as “New Zealand’s bold strategy for reducing health disparities” (Alcorn, 2011, p. 1689), aims to achieve a state of maximum health and wellbeing for whānau (Ministry of Health, 2002) by supporting whānau and communities to identify and drive their own development objectives (Alcorn, 2011). In 2009, as a starting point for defining the scope, nature and possible strategies for the achievement of Whānau Ora, the Taskforce on Whānau Centred Initiatives was established (Boulton & Gifford, 2014; Boulton, Tamehana,

& Brannelly, 2013). Its chief purpose was to build an evidence-based framework that would lead to, amongst other things, strengthened whānau capabilities, an integrated approach to wellbeing, and collaborative relationships between state agencies in relation to whānau services. *Whānau Ora: Report of the Taskforce on Whānau Centred Initiatives* (Taskforce on Whānau Centred Initiatives, 2010) outlined a five-part framework to address these goals, further entrenching the concept of whānau ora in health service delivery for Māori, and also in the wider social services sector. The vision encapsulated in the concept of Whānau Ora as described in the Taskforce report is now recognised as a key public policy initiative to address the “complex and intractable issue” (Head, 2008, p. 107) of Māori inequity.

The growing acceptance of Whānau Ora as a philosophy focusing on the health of the whole family, not just the health of the individual, and a distinct model of practice embracing the health and social service sectors (Boulton & Gifford, 2014) has led to a concomitant rise in interest as to the efficacy of the model, its relationship to other frameworks, and its generalisability and utility beyond Māori health and social services. A further consequence of the “normalisation” and acceptance of Whānau Ora in the health and social service sector discourse has been the interest shown by research funders and government departments to fund research that explores aspects of whānau ora.

The material presented in this paper represents one set of findings from a larger study that emerged as a consequence of just such a research partnership. The study, entitled “Facilitating Whānau Resilience through Māori Primary Health Intervention”, was funded through the Health Research Council Partnership Programme as part of the Whānau

1 Whānau Ora (capitalised) is used to refer specifically to the New Zealand Government’s Whānau Ora approach to social service delivery, particularly as outlined in *Whānau Ora: Report of the Taskforce on Whānau-Centred Initiatives* (Taskforce on Whānau Centred Initiatives, 2010), and initiatives arising from this approach such as the programme of Whānau Ora Action Research and the funding of specific Whānau Ora Providers. However, the term “whānau ora” (non-capitalised) is used to refer to any other approach to whānau ora, or a state of wellbeing more generally.

Ora Research Partnership, a joint research initiative funded by the Health Research Council of New Zealand, Ngā Pae o te Māramatanga, the Families Commission and the Accident Compensation Corporation.

In this paper we seek to achieve two objectives. The first is to explore whether the concept of resilience has resonance in the New Zealand Indigenous context. The second is to discuss the link between the concept of resilience and the Māori concept of whānau ora. To achieve the first objective we begin by outlining the process by which our research team came to understand the concept of resilience. The review we conducted on the concept of resilience in the international and local literature, and which we summarise here, helped shape our understanding of the extent to which the term resilience was understood in the New Zealand Indigenous context. We then present the conceptual framework developed to guide the study. The second objective, an examination of the link between the concept of resilience and the Māori concept whānau ora draws on data from key informant interviews and sequential focus groups to present an emergent understanding of the relationship between resilience and whānau ora.

## The study

The study was conceptualised as a piece of health services research, meaning we were particularly interested in understanding how knowledge of concepts such as resilience can inform the practice of health care service delivery to Māori consumers of health services. Consequently we partnered with a local Māori health service provider, Te Oranganui Iwi Health Authority (TOIHA), to explore notions of resilience and whānau ora in a “live” service setting.

TOIHA is a mixed urban and rural Māori primary health care organisation in Whanganui with an enrolled population of 7,414 clients (TOIHA, 2008). The proximity of the case, and the fact that TOIHA has a very clear

understanding of what constitutes whānau ora for its community, made this service the ideal partner for a study investigating the concept of whānau resilience.

The study was divided into two distinct phases of enquiry. Phase 1 sought to identify whether and how concepts of resilience were incorporated into the TOIHA whānau ora programme approach, while phase 2 determined evidence of implementation of these concepts. In particular, we sought to understand how participation in Māori primary health services had impacted on whānau resilience capacity. The primary data-gathering techniques included a comprehensive literature review; case study (organisational) document review; in-depth, semi-structured key informant interviews; and sequential focus groups with health service consumers.

In this paper we report on only two sets of findings from the larger study in order to address this paper’s objectives, which are to explore whether resilience has resonance in the New Zealand Indigenous context, and the link between the concept of resilience and that of whānau ora. Our conceptual framework represents the first set of findings and emerged from an analysis of the international and national literature as well as the health service’s own documentation. The second set of findings is drawn from key informant interviews.

## Study limitations

There were a number of limitations to the full study, not the least of which being a pre-determined focus for the research. The Request for Proposals for this initiative specifically sought research that would focus on “whānau resilience” (a term defined by funders as meaning the collective health and wellbeing of whānau at a level beyond individuals, families and individual households), addressing the factors that promoted, and contributed to, whānau health by maximising whānau

resilience (Health Research Council, 2008). In response, we constructed our study so that we could first investigate whether the concept of resilience was understood by members of our community; that is, Māori whānau.

A second limitation of the study was its size, being a small, single case study. Case study design is particularly suitable for “gather[ing] comprehensive, systematic, and in-depth information” (Patton, 2002, p. 447) with the aim of exploring both the complexity and uniqueness of the case selected. However, given that the research is based on a single case, care must be taken when considering how the results could be generalised to other services or indeed to primary care more widely.

### The literature review

Given the study’s origins, the literature review we undertook had a specific focus on how the concept has been applied to Indigenous peoples and particularly how the term was being applied to Māori whānau and communities. Two main searches were undertaken: the first to look for scholarly writing on aspects of Indigenous resilience, and the second to look for material linking whānau ora and primary health care. Both searches were restricted to peer-reviewed journal articles and grey literature from 1998 onwards. Search engines and databases included Medline, CINAHL, Proquest Medical Library, Sage Premier Journal Collection, PsychInfo, the Australian Medical Index, and Mednar. More detail on the search protocols and the results of the second search, linking whānau ora and primary care, can be found in our technical report (Boulton, 2012).

### *Resilience and the social sciences*

The origins of the use of the term resilience in the social sciences can be traced to the longitudinal child health studies undertaken some 40 years ago where it was used with respect

to children to describe the ability to overcome adversity (Green, 2008). In the social sciences, two distinct approaches to resilience are apparent. The first, emerging from social cognitive theory, asserts that individuals are agents, being both producers of experiences and shapers of events (Bandura, 2000). The concepts of self-efficacy (the belief in one’s own ability to change hazardous behaviour) and collective efficacy (a group’s shared understanding of its ability to meet its goals and complete agreed tasks) derive from this understanding of the nature of human behaviour. A strong sense of personal or self-efficacy is related to better health, higher achievement and more social integration (Bandura, 2000; Schwarzer, 1994).

The second approach considers resilience in a broader, ecological sense, where resilience is dependent upon, or can be mitigated by, the relationship between the individual and their environment. Up until the late 1970s, the study of resilience was largely concerned with understanding the mix of risk and protective factors which contributed to some individuals successfully remaining invulnerable in the face of adversity and able to withstand both ongoing and acute difficulties (Wexler, DiFluvio, & Burke, 2009). Resilient people, it was assumed, possessed fixed and immutable personal qualities. Emphasis was placed on determining whether these same qualities could be fostered in the less resilient and subsequently successfully incorporated in programmes of intervention, particularly with children (Green, 2008).

Consistent with its origins in the traditions of Western psychological science and in a discourse of illness, resilience was initially positioned as an individual and relatively static construct, bearing little relation to historical or cultural context (Ungar, 2005a). Individuals “failing” to demonstrate resilience could be “blamed” for this failing as it was considered that one’s life course was largely a matter of personal choice and personal discretion. Despite these shortcomings, this approach to constructing

resilience continues to inform a segment of the contemporary literature on the subject (Fleming & Ledogar, 2008).

### ***Family and community as protectors of resilience***

Resilience research has progressed from considerations of the individual as the focal point for analysis to incorporate broader concepts of family and community resilience (Blackstock & Trocmé, 2005; Patterson, 2002; Walsh, 1998). Social work recognises that an individual's capacity to exhibit resilience depends on more than simply some innate characteristic within the individual themselves (Ungar, 2005a). Rather, there are a number of external protective factors which contribute to an individual's resilience and capacity to cope with trauma and adversity (Fleming & Ledogar, 2008). Protective influences may be found in family and community systems and processes, and include aspects such as parental warmth through to supportive peers (Fleming & Ledogar, 2008). Community resilience is illustrated by characteristics such as health-promoting physical environments, residents' wellbeing and positive social relations (Jackson et al., 2003). Resilience-promoting organisations may include schools, for example (Wong et al., 2009).

The concept of cultural resilience—resilience as a feature of whole communities and cultural groups (Fleming & Ledogar, 2008)—has also gained prominence. Cultural resilience may address gender, sexual orientation, ethnicity and economic class. The growing interest in how culture may influence individual, family and community resilience has provided an opportunity to explore new approaches to understanding the term resilience. One such reframing of the term seeks to reposition resilience as a process and as a practice, recognising that resilience, far from being static, is a dynamic and fluid concept with inextricable links to social, historical and cultural context. This approach is represented in the current

work on youth resilience led by Dr Michael Ungar of the Resilience Research Centre in Canada and in his work on the International Resilience Project ([www.resilienceproject.org](http://www.resilienceproject.org)).

### ***Indigenous and cultural resilience***

Indigenous researchers and academics are also beginning to contribute to this “reframing exercise”. Globally, there is comparatively little published or unpublished material available that explores and critiques the concept of resilience from an Indigenous perspective. Only very limited efforts within Indigenous health research have been made “to directly explore the potential usefulness of a resilience framework from the perspectives of Aboriginal peoples” (Iwasaki & Bartlett, 2006, p. 17).

For some North American academics, the concept of resilience is intimately linked with an oppressive and destructive colonial history and cannot, as a result, be viewed without deep suspicion. Further, there is an implicit assumption that resilience is disconnected from the imposed systems of social power that shape the lives of Indigenous peoples. Health and healing are thus constructed as being largely within the control of individuals, including those who are systematically disempowered. Green (2008) agrees, noting a major flaw of resilience literature is its concern with understanding how the individual might cope and respond to disadvantage, rather than an analysis of how structures, systems and processes perpetuate disadvantage for Indigenous peoples. Accordingly, even adopting the language of resilience risks silencing Indigenous stories of success and failure. To counteract the prevailing hegemony, Lavalley and Clearsky (2006) advocate for an Aboriginal-centred process that allows health and healing stories to be shared within a decolonised analytical framework.

The majority of Indigenous writers recognise that Indigenous views of resilience go beyond the focus on the individual (Andersson, 2008), that analysis needs to address both the historical and

contemporary oppression that exists (Walters & Simoni, 2002), and the theorising of resilience must place structural inequality at the centre of the discourse.

### ***New Zealand and kaupapa Māori resilience literature***

In New Zealand, resilience research primarily focuses on issues around youth resilience and empowerment (Sanders, Munford, & Leibenberg, 2012); youth mental health and the misuse of alcohol and drugs (Clark, Robinson, Crengle, & Watson, 2006; Fergusson & Horwood, 2003); resilience as a protective factor in contraception, managing sexually transmitted diseases and HIV in youth and adult populations, and managing sexual coercion (Clark et al., 2006; Green, 2008; Moewaka Barnes, 2010); and more generally, as a framework to understand the protective factors apparent in families and communities of immigrants and migrants (Dixon, Tse, Rossen, & Sobrun-Maharaj, 2010). The examination of protective factors that promote good outcomes or “resilience” in youth health research is a relatively new phenomenon (Clark et al., 2006); however, the idea of a “resilience framework” which seeks to understand and identify factors that protect vulnerable youth and encourages them to thrive is gaining attention in New Zealand. The resilience framework acknowledges that behaviour is influenced by the complex interplay of individual, biological, social, cultural, environmental, societal and historical influences (Flay, 2002; Waller, 2001), and according to Clark et al. (2006), seems consistent with Māori aspirations for development of capacities and self-determination.

Māori literature on the concept of resilience in the health and social sciences is limited and Māori critiques are few, as has been noted by Moewaka Barnes (2010). Green (2008), in contrast to Clark, notes that Western resiliency frameworks have limited relevance for Māori. Specifically, Green argues much of the Western

discourse assumes that changing the behaviour of non-resilient, disadvantaged individuals will effect resilience, an assumption which fails to recognise the structural factors which shape disadvantage in the first instance. Similarly, Te Puni Kōkiri (2009, p. 5) concluded that to conceptualise resilience in terms of “risk” and “protection”, and how individuals respond to risk, does not take account of the continuing influence of socio-economic status, gender, culture and ethnicity on Māori.

While there is growing interest in the term resilience and its relevance to the development of public policy (Dixon et al., 2010; Kalil, 2003; MacKay, 2003; Moewaka Barnes, 2010) and health and social service delivery, our understanding of resilience, and importantly its relevance to Māori whānau and communities as a force for societal transformation, is still relatively unsophisticated. Equally, our understanding of the association between resilience and concepts firmly grounded within a Māori worldview such as whānau ora or mauri ora requires further exploration.

### **Using the literature review to develop a conceptual framework**

Our review of the literature revealed little evidence of a relationship between whānau resilience and Māori primary health concepts and interventions (Boulton, 2012; Boulton & Gifford, 2011). There was also a lack of research exploring how engagement in Māori primary health services could strengthen whānau resilience through improved access to health resources. Despite the lack of Māori-specific material, given what we had learned in our review of the resilience literature, and particularly Ungar’s description of resilience as a dynamic and fluid concept with inextricable links to social, historical and cultural context, we theorised that notions of resilience do, in fact, underpin Māori primary health activity. Further, we theorised that Māori primary health

approaches have the ability to assist whānau to increase their resilience by supporting individuals and whānau to access resources that sustain their wellbeing in culturally meaningful ways.

Our study was premised on a positive Māori development model in that it assumed that whānau and providers together have the capacity to generate change and enhance whānau ora (Cram, Smith, & Johnstone 2003; Durie, 2003; Ellison-Loschmann & Pearce, 2006). With this starting point in mind we set out to construct a conceptual framework to help us understand the linkages between resilience, whānau ora and the work of a primary health care provider when working with Māori whānau. For the purposes of the research we adopted a definition of resilience employed by Michael Ungar (2008) which proposes that resilience is

both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual's family, community and culture to provide these health resources and experiences in culturally meaningful ways. (p. 225)

With this definition in mind, we examined three existing frameworks to determine the core aspects of resilience and whānau ora, and inform the development of a conceptual framework. Therefore, the three existing frameworks informing the conceptual framework for this study included Ungar's (2008) definition of resilience; the Whānau Ora principles (Taskforce on Whānau Centred Initiatives, 2010); and Te Puni Kōkiri's Māori Potential Framework, an approach that aims to better position Māori to leverage off the potential of their collective resources, knowledge, skills and leadership capability to improve their overall quality of life (Boulton & Gifford, 2011).

We then reviewed TOIHA's internal policy and practice documentation with the aim of distilling those features that aligned with resilience,

as defined in the literature (Boulton & Gifford, 2011). In summary, TOIHA's approach to providing culturally appropriate health services draws upon its accountability to, and mandate from, Whanganui iwi. TOIHA seeks to incorporate a holistic and Māori worldview approach to supporting Māori whānau to reach their potential as Māori, with a focus on wellness rather than illness (TOIHA, 2008).

Consequently, we identified four elements of TOIHA's approach to health service delivery that strongly aligned to understandings of resilience. Importantly for Māori, these elements not only supported notions of individual resilience but also notions of whānau resilience. The four elements include a whānau ora approach, cultural accountability, a focus on wellness, and whānau empowerment. Table 1 provides an illustration of the various frameworks we used to develop the conceptual framework for this study, and the four elements identified.

### **Examining the links between resilience and whānau ora**

To further ascertain the links between notions of resilience and whānau ora and the evidence of a resilience approach in TOIHA's service delivery, we collected two sets of data: key informant interviews with TOIHA governors, managers and front line workers, and sequential focus groups with service users.

### **Methods**

Using the results of the conceptual framework as a guide, 11 individual semi-structured interviews were conducted. Details on the process for these interviews can be found in a subsequent publication (Boulton & Gifford, 2011). Interviews were taped and thematic analysis undertaken by the research team to ascertain themes. To ensure reliability of data the lead interviewer independently coded data to reduce any potential loss of meaning from

TABLE 1 Frameworks incorporated into the study's conceptual framework

Māori development approaches in health service provision	Ungar's definition of resilience	Elements of Te Oranganui Iwi Health Authority's whānau ora service delivery approach that align with resilience
<ul style="list-style-type: none"> <li>• Whānau Ora principles (inter-agency, whole-of-family approach)</li> <li>• Māori potential framework (using collective resources to improve overall quality of life)</li> </ul>	<p>“the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual's family, community and culture to provide these health resources and experiences in culturally meaningful ways” (Ungar, 2008, p. 225)</p>	<ul style="list-style-type: none"> <li>• Whānau ora approach</li> <li>• Culturally accountable and appropriate care</li> <li>• Focus on wellness and ability to provide appropriate resources</li> <li>• Empowerment of staff, clients and their whānau</li> </ul>

body language or facial expressions (Miles & Huberman, 1984). A team of four senior researchers acting as a group undertook a further stage of analysis and synthesis termed “Mahi a Roopū” (Boulton, Gifford, Kauika, & Parata, 2011). This involved the team reviewing all transcripts and draft themes that had been identified by the lead interviewer, analysing the transcripts thematically against the interview schedules to draw out the key messages, and analysing transcripts for new, emergent themes. All data were considered in terms of their alignment to the study's conceptual framework.

Sequential focus groups (SFG) were conducted with service users to understand how being a TOIHA client had impacted on whānau resilience. The SFG method, an approach to qualitative research initially developed by a team of Indigenous researchers in Canada, builds upon the conventional method of conducting focus groups but provides sufficient time for participation in the cultural rituals crucial for engagement with Indigenous participants (Boulton, 2012). The same participants meet as a group, over a course of at least four sessions. The SFG method offers a way for researchers and participants to explore the issues in depth by providing sufficient time for critical reflection.

Two SFGs were conducted, each SFG

comprising four separate focus group sessions. Group A comprised six participants, while Group B comprised eight participants. A series of questions was used to guide each individual session. The duration of each session was three hours, representing a total of 12 hours for an entire SFG data set. Participants were recruited by TOIHA staff and comprised adults between the ages of 18 and 65 who considered TOIHA their primary place of health care and who had accessed the health services a minimum of three times in the last two years. Of the final 14 participants, 4 were male and 10 were female. Most of the participants (71%) accessed TOIHA services monthly or bi-monthly, either to visit their general practitioner or for other primary health care services. All but one participant were Māori.

### Discussion: Drawing the threads together

We have drawn upon the high level themes that emerged from both data sets for this section of the paper. This section discusses participants' understandings of resilience, the links between whānau ora and resilience, and the contribution of TOIHA to whānau resilience. It also presents an emergent theoretical model of the

relationship between the two concepts of resilience and whānau ora.

### *Understandings of resilience*

Participants talked about resilience in three ways: as a personal quality, as a process, and in relation to the collective. As a personal quality, someone who exhibited resilience had strength of character or spirit and possessed certain values which allowed them to overcome adversity and trauma. Toughness, the ability to bounce back, resourcefulness, adaptability and flexibility were all regarded by participants as characteristics of a resilient person. Participants did not necessarily agree that resilience was an intrinsic characteristic, one people are born with; rather, some participants were of the view that resilience could be “learned” through experiencing setbacks. Some participants spoke of the “school of hard knocks” and how people demonstrated resilience by surviving a disadvantaged upbringing to become well-regarded members of society. Others spoke about the values that are taught to Māori who were fortunate to grow up amongst their elders. Demonstrating resilience does not occur in isolation but relies on connections to other people. These people may, in turn, perform a variety of functions—for example, as catalysts for change; mirrors to reflect back to the person the direness of the situation; guides; champions or advocates; role models; and supporters.

Participants commented that there are whānau who appear to be more “resilient” than others. These more resilient whānau, it was believed, have greater access to “natural resources” including family (particularly extended family), friends, links to their marae and other institutions of culture, including places of significance (such as wāhi tapū, mahinga kai, awa and maunga). These whānau and individuals are often “more educated” and have a greater knowledge of their rights as consumers of health care services.

A second understanding of resilience raised

by participants was the concept of resilience as a journey or a process. For example, participants talked about situations where a person moves from a “bad” life, characterised by trauma, risk or harm, to a life which is healthier and safer. Participants spoke of the requirement for a catalyst or “trigger” to prompt the person to recognise the need to embark on their journey. These triggers may take a variety of forms, from a traumatic or significant incident (for example, the death of a parent or birth of a child) through to something as simple as a conversation with someone held in high regard.

The third form of resilience identified was collective resilience. The ability of iwi to “bounce back” from war and disease was cited as an example of such resilience. Participants observed that in a modern context, collective resilience (the resilience of whānau, hapū or iwi) remained an important concept, but that the types of adversity experienced by collectives had changed. Participants commented that contemporary whānau have to be resilient simply because there are so many attacks on the traditional whānau structure as a consequence of intergenerational trauma, acculturation and adaptation to the contemporary lifestyle. Participants spoke about the breakdown of the traditional family unit and the breakdown of the concept of whānau. Participants commented on how common it was nowadays to see “blended” families and single-parent families or for children to be raised by a sole caregiver who is not their biological parent.

Participants also commented that the ties that have kept iwi, hapū and whānau strong in the past have broken down through the process of colonisation. The concept of a Māori collective resilience depends on whether Māori still regard their iwi, hapū and marae as their community, or whether other forms of community have now taken primacy. Participants noted that Māori are now mobilising themselves into new collectives, with examples being the communities that are being formed in Australia, gang families and, to some extent, the extended

family one joins if one participates in some of the more evangelical churches.

### ***Linking whānau ora and resilience***

Participants also agreed that whānau ora and resilience are connected. Both concepts were seen to involve a process or a cycle of growth and development both at the personal and at the whānau level. The achievement of resilience and whānau ora both required the support, help and assistance of others. Participants agreed that an individual could not become resilient, nor reach a state of whānau ora, on their own. While some will seek support and assistance from outside of the family, through health and social service agencies, others will turn inwards and look to their own whānau and extended whānau for advice and assistance.

In further discussing the links between resilience and whānau ora, participants noted that resilience may well be viewed as a stepping stone towards the achievement of whānau ora. Participants discussed needing a certain level of resilience as an individual or a whānau in order to reach the goal of whānau ora. Participants agreed that whānau ora “is about being well”, and that to be well you will need certain capacities and strengths. The multitude of capacities and strengths that individuals and whānau have to draw upon may be regarded as “resilience”. Hence, whānau ora cannot be achieved without a degree of resilience on the part of the members of that whānau.

### ***The contribution of TOIHA to whānau resilience***

Participants commented that TOIHA plays an important role in assisting individuals and whānau to weather adversity. Specifically, health promotion and health education workers were regarded as having an opportunity to inform, educate, teach, and demonstrate through role modelling, good health behaviours and practices. As a Māori health provider,

TOIHA supports people to achieve their own goals in a manner that respects their rangatiratanga, cares for people as if they were their own, and strives to be there for people in both the best of times and the worst of times. Timely, high quality, culturally informed one-on-one support of the client (and wider whānau), the ability to access a range of resources offered by the organisation, and effective referral processes were features of the organisation that allowed it to enhance whānau resilience to the point where whānau were eventually able to realise their potential.

While it is important to recognise that not all Māori face the same levels of adversity, participants in this study observed that, for some individuals, going to a health service such as TOIHA may be the “spark” that is required to move people from a place of risk to a healthier life, providing the impetus for change. In such cases, participants noted that it then became the responsibility of the health provider to support the individual through their journey, to provide appropriate education, tools and resources so that the individual, having recognised the need for change, is not “abandoned” with their decision.

Participants commented on the fine balance that a health service must maintain between “doing for” clients—therefore making them dependent on the service and less self-reliant—and “empowering” individuals and whānau to make the necessary changes in their lives. Participants spoke about “victim whānau” who may be engaged with a service for years, not necessarily because they need a high degree of support, but because they have an attitude that they cannot help themselves. Participants commented that self-motivated whānau who recognise the need for change and are prepared to do so will have the most to gain from engagement with a health service.

### ***Theorising the relationship between whānau ora and resilience***

Resilience, in the context of this Māori primary health care provider, concerns access to resources, enabling personal autonomy, facilitating whānau-based problem solving and a whole-of-whānau perspective on health and wellbeing. Resilience as conceived of, and discussed by our participants is not simply about personal attributes by which an individual can overcome trauma, but is also about the process or journey taken to overcome the trauma and the supports that are required when a person or whānau recognises there are changes to be made. Resilience therefore is also about how as a collective, whānau, hapū and iwi can respond to and mitigate the effects of trauma, marginalisation and stress. For participants in this study, resilience, whether demonstrated at an individual or whānau level, required reclamation of, and adherence to, some of our more basic and fundamental values as Indigenous peoples: acting as a collective, holism, accessing culturally appropriate resources, determining our own priorities, whānau cohesion, and looking after the entire whānau.

Ungar, in a discussion of the social service delivery systems that influence resilience in children, describes a range of health resources that may be drawn upon to navigate a pathway to resilience (Ungar, 2005b). Recognising that health resources might be “navigated” and “negotiated” (Ungar, 2005b, p. 424) is important to understanding Māori views of resilience. Whereas resources in a more traditional sense may mean access to information, education or even human resources such as mentors or leaders, for Māori the concept of resources also includes those cultural institutions of Māori society that support Māori development. Such resources include land; societal institutions such as marae or traditional gathering places; multi-faceted models of health that acknowledge both the spiritual and the terrestrial realms of wellbeing; language; the environment; and

so on. Access to these more holistic resources is often mediated by, or occurs as a result of, believing in and acting upon a certain set of values grounded in te ao Māori.

Given that many Māori still access the institutions of culture as part of their collective set of resources, what then is the relationship between the concept of resilience and that of whānau ora? A resilience approach, when discussed in the context of Indigenous peoples, is often underpinned by a focus on adversity and hardship, and constructs a reality from a position of scarcity, hazard and risk. Whānau ora, however, is used, understood and applied in the health and social services sector quite differently: whānau ora is regarded as an aspirational goal, one that does not assume a state of adversity as the norm. Rather, whānau ora is underpinned by a strengths-based approach to health and wellbeing, one which seeks to maximise the potential of whānau and individuals as members of whānau collectives. At the core of the whānau ora approach is the belief that Māori are the key catalyst for achieving exceptional life quality for themselves, their whānau and their communities.

Participants in this study were able to draw a link between whānau ora and resilience. They noted that essentially whānau ora “is about being well”, and that to be well, individuals and whānau draw on a set of unique attributes, capacities and strengths. For whānau that are already well, these strengths will be many. However, more vulnerable whānau may have very little on which to draw. It is the combination of the broader capacities and strengths that individuals and whānau have to draw upon that determines how “resilient” one is as a whānau or as an individual. According to our participants, whānau ora is linked to resilience because whānau ora will not be achieved without a degree of resilience or capacity on the part of wider whānau members.

Drawing on Ungar’s more recent work on ecological understandings of resilience, where resilience is only understood by first

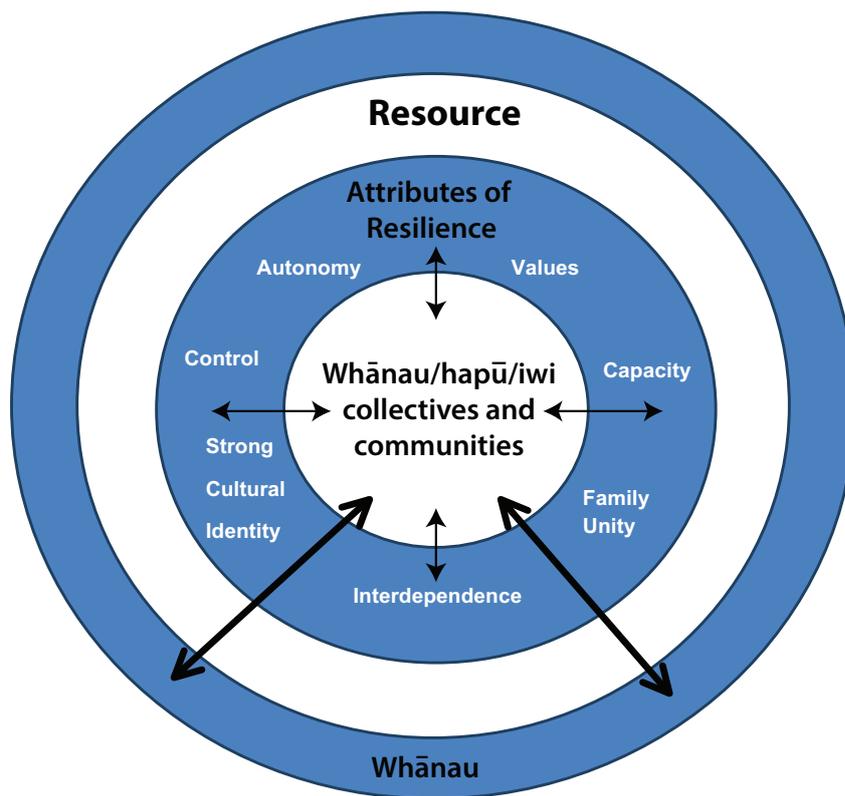


FIGURE 1 The relationship between resilience and whānau ora

understanding the context in which an individual experiences adversity (Ungar, 2012), we contend that resilience is an attribute whānau, hapū, iwi and communities must possess in order to attain whānau ora. Hence, resilience is itself an attribute of whānau ora. The relationship between resilience as an attribute and whānau ora as a high level population outcome are represented in Figure 1.

## Conclusion

In his recent text, Ungar observed that researchers continue to report “definitional ambiguity” in how to define the positive development that occurs under conditions of adversity. In part, Ungar argues, this is due to the misapprehension that resilience is simply a set of attributes an individual can possess. Rather, he notes resilience must also be considered as a process that families, communities, governments and,

by extension, health providers can facilitate (Ungar, 2012). This research clearly identified a series of resilience-enhancing processes facilitated by this case study site.

Both resilience and whānau ora acknowledge that trauma, risk and adversity exist for certain groups within the population. Both acknowledge that whānau, families, collectives and communities have the ability to resist and overcome adversity, and both recognise that it is up to whānau, families, communities, collectives and governments to provide the resources that will enable whānau to bolster their wellbeing in culturally appropriate and sustainable ways. Acknowledging the distinctiveness of whānau and their resilience when supporting whānau members through adversity has been recognised as a crucial step in the path to achieving whānau ora (Te Puni Kōkiri, 2009). We agree, contending further that Māori primary health providers also play a vital role, not only in the achievement of whānau ora, but also in

supporting whānau resilience. Where Māori health providers are able to deliver health care using a whānau ora approach specific to their unique community, such an approach will also facilitate individual and whānau resilience. We therefore encourage the Māori health sector to use the full range of resources at their disposal to configure services to support those individuals and whānau who, recognising their own resilience, want to take the journey towards better health and achieve the ultimate goal of whānau ora.

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**Glossary**

awa                      river  
 hapū                    sub-tribe  
 iwi                        tribe

mahi a roopū	a method of analysing qualitative data using a team approach, literally “work of the group”
mahinga kai	traditional food and other natural resources and the places where those resources are obtained
marae maunga	meeting house, meeting place mountain, particularly an ancestral mountain
mauri ora	a force that generates and sustains life, vitality and health
rangatiratanga te ao Māori	ownership, dominion the Māori world
wāhi tapū	a sacred place or site of significance
whānau	family, usually referring to extended rather than nuclear family
whānau ora	The official Ministry of Health definition is “Māori families supported to achieve their maximum health and wellbeing” (Ministry of Health, 2002). Whānau ora may, however, be defined and interpreted differently by individual health and social service providers, communities, iwi, hapū and whānau.
Whanganui (Wanganui)	a small provincial town on the west coast of the North Island of New Zealand

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