

Traditional rongoā Māori healing is the subject of a \$1 million research grant from the Health Research Council. A trio of researchers from Whanganui-based Whakauae Research for Māori Health Development (WRMHD) will work with Canterbury University Māori health and well-being lecturer Annabel Ahuriri-Driscoll and rongoā Māori practitioner Albert Stewart of Tairāwhiti. The three-year project will look at rongoā Māori in a contemporary health care setting and determine what types of service arrangements best support and maintain the cultural integrity of traditional rongoā.

Amohia Boulton from WRMHD said they hoped to demystify the sector while building on previous research. "From the study a 'map' of rongoā service providers and a service development model will be developed . . . as a practical tool to support and inform practitioners who wish to improve their rongoā service," she said.

The Waitangi Tribunal has recently released a major report Ko Aotearoa Tēnei, into the claim known as Wai 262. This concerns the place of Māori culture, identity and traditional knowledge in contemporary New Zealand law, and government policy and practice. The claim is about

mātauranga Māori, ie the unique Māori way of viewing the world, encompassing both traditional knowledge and culture. The report includes a chapter on rongoā Māori (see p15).

Far North nurse practitioner (NP) Adie Murray uses rongoā Māori in her practice. "Rongoā Māori is complex. *Herbal preparations and use are part of it.* So, too, are other dimensions of well-being Māori consider when caring for a person. These include te taha, waioara, hinengaro, tinana, mauriora, toiora, whenua, whakapapa and te reo. I use these care dimensions in an appropriate manner. How I do this safely is articulated in the Nursing Council's competencies for a whānau ora NP with prescribing rights."

Using rongoā Māori was an holistic approach to health care. "I will greet my clients in te reo Māori. Clinical examination involves a head-to-toe assessment including all the care dimensions. If a client chooses to discuss whakapapa with me as a Māori clinician, I am happy to do so. When choosing treatment options, my care must be appropriate (mauriora/toiora – culturally/environmentally acceptable), accessible (whenua – where do they live?) and affordable."

Murray says it is not unusual for a Māori per-

son, taught or brought up with rongoā Māori, to use it within their whānau. "In my opinion, use of rongoā Māori in one's life is to be well. That is my understanding of the broader context of rongoā, as my late father advised."

The Tribunal's report states more widespread use of rongoā Māori services would help the current Māori health crisis and Murray agrees. "If we view rongoā Māori in its broader context, which includes 'traditional medicines, karakia and ritenga', then I believe, as a nation, we can't afford not to use it."

She believes both Māori and non-Māori clients accessing care should have choices about their care and treatment. "Why not rongoā Māori? I think public acceptance of rongoā Māori practice depends on transparency so the public can have confidence in its safety. I can't speak on behalf of all rongoā Māori practitioners, but from my viewpoint, as a Māori clinician using the dimensions of rongoā Māori, I can say my care is transparent, is based on both cultural competencies and science, is provided within a framework of evidenced-based best practice and is monitored to ensure appropriateness. This approach ensures public confidence." •

MEDICINE REGULATIONS AMENDED BEFORE REVIEW OF MEDICINES ACT

The Medicines Regulations 1984 and the Medicines (Standing Order) Regulations 2002 have been amended to better align the law with modern health care. The amendments mainly concern advertising, labelling and dispensing and the sale of medicines. The amendments have preceded the review of the Medicines Act which

NZNO expects will align the prescribing rights of all health professionals and provide definitions of authorised and designated prescribers. The standing order amendments require a standing order to specify whether countersigning of a charted treatment is required and, if so, the requirements for countersigning. If coun-

tersigning is not required, or is required less frequently than once each month, the issuer must carry out a monthly audit of a sample of charted treatments.

A new schedule of medicines is included, along with an updated list of registration authorities. •

ACTION TO ADDRESS ONGOING HEALTH INEQUITIES

Health inequalities result from social inequalities and action on them requires action across all the social determinants of health. This is the mantra of the director of the International Institute for Society and Health, Sir Michael Marmot, guest speaker at last month's Marmot Symposium in Wellington. He was invited by the New Zealand Medical Association (NZMA), as part of a stocktake on how to address ongoing health inequalities here. He spoke at a series of activities and symposia convened by the Heart Foundation and the University of Otago, Wellington.

Marmot chaired the World Health Organisation's Commission on Social Determinants of Health, led the recent "Marmot Review" of health inequalities in England and Wales, and has just completed his term as president of the British Medical Association.

Taking universal actions to reduce the steepness of the social gradient in health was one of the key messages to emerge from the review of health inequalities in England and Wales, Marmot said. However, actions needed to be on a scale and intensity proportionate to the level of disadvantage, ie a balance of targeting and universalism. Giving every child the best start in life and creating fair employment and good work for all were some of the policy objectives needed to reduce health inequalities.

The NZMA has published fact and action sheets on health inequalities in New Zealand, prepared by University of Otago public health medicine specialist Tony Blakely and GP Don Simmers. As well as outlining progress (eg the slight decrease in the gap between Māori and non-Māori life expectancy, and New Zealand's

commitment to becoming smoke free), the fact sheets also point to high child poverty rates and poor social outcomes among children and youth.

The fact sheets offer "the ten next most important actions to reduce health inequalities". These include equitable and fair fiscal and social welfare policy (including progressive taxation); maintaining and enhancing social cohesion through ensuring all services are accessible by all; aligning climate change, sustainability and pro-equity policies; ensuring fair employment and safe, healthy workplaces; maintaining and enhancing Māori, Pacific and Asian policies and programmes; and continued research into health equity, focusing on what works. For the full text, go to www.wnmeds.ac.nz/academic/dph/research. •