



Understanding Childhood Immunisation Rates for Tamariki Māori in the Counties Manukau and Waikato Regions

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Abstract

In 2024, the rates of fully immunised tamariki Māori (children) in Counties Manukau and Waikato regions were lower than both the national Māori average of 63% and the national target of 95%. PHF Science, New Zealand's infectious diseases research platform (previously

ESR), contracted Te Rau Ora, a national Māori health and wellbeing organisation, to better understand how to help lift childhood immunisation rates, specifically in these regions. Te Rau Ora engaged with local iwi (tribes) and Māori health providers in the Tainui waka (canoe) tribal area through Raakai, a kaupapa Māori research project, aiming to better understand immunisation uptake and services for tamariki Māori. A mixed methods approach included literature review, survey (n=1,276), and direct engagement with local whānau (families) and Māori health providers. Hui ā-Rohe (Area based gatherings) and interviews provided whānau and frontline worker insights into immunisation services. Evaluative methodology supported ongoing learning and evaluative reasoning to develop actionable insights. Raakai shows that tamariki Māori immunisation rates in Counties Manukau and Waikato reflect structural inequities rather than individual hesitancy, and that Māori-led, including marae-based approaches, offer critical pathways that (re)build trust enhancing access to immunisation and general health services.

Keywords: Immunisation, tamariki Māori, Māori health, Waikato, Counties Manukau, Tainui

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Mokau ki runga, Tamaki ki raro, Mangatoatoa ki waenganui. Pare Hauraki, Pare Waikato Te Kaokao roa o Patetere ki te nehenehenui. He piko, he taniwha, He piko, he taniwha, Waikato taniwha-rau.

The tongikura (Kiingitanga saying) above defines the geographic and tribal boundaries of the Waikato-Tainui iwi confederation, encompassing both the Counties Manukau and Waikato regions of Aotearoa New Zealand.

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Introduction

Childhood immunisation coverage in Aotearoa New Zealand has dropped since 2017, with the impacts of the COVID-19 pandemic accelerating the decline in childhood immunisation rates (Iusitini et al, 2026). The Health New Zealand (2025) immunisation coverage data shows rates among tamariki Māori remains substantially lower in Waikato and Counties Manukau than in most other regions, highlighting the ongoing need for targeted Māori-led immunisation initiatives. Nationally, 50% of Māori children were fully immunised by 6 months of age, in Waikato 42% and Counties Manukau 38%. At 18 months of age, national Māori coverage was 47%, compared with 42% in Waikato and 35% in Counties Manukau (Health New Zealand 2025). These figures demonstrate persistent inequities in childhood immunisation coverage for tamariki Māori and reinforce concerns about increased vulnerability to vaccine-preventable diseases in these regions

In 2022 PHF Science established Te Niwha, a three-year funding term (2022-2025) to strengthen New Zealand's preparedness and response to infectious disease threats. This project was part of a \$50 million fund to support

Māori health providers and services nationally to increase childhood immunisation uptake in 2024 and 2025 (Reti, 2023). As part of Te Niwha, Te Rau Ora was tasked to better understand Māori childhood immunisation to help lift immunisation rates in Counties Manukau and Waikato. Te Rau Ora engaged with local iwi, and Māori health providers to implement Raakai - a kaupapa Māori multi-method research project dedicated to understanding immunisation delivery and services for tamariki Māori in these two regions.

Raakai (or rāakai) translates as “to adorn, embellish” and was presented by the Pou Tikanga (Māori cultural supervisor/advisor) for this initiative to reflect a distinctly Māori worldview of protection, wellbeing, and collective responsibility. Within the context of this project, Raakai symbolises wrapping our pēpi (babies), tamariki, whānau (families) and communities in protection through actionable insights around immunisation. Much like notable Waikato leaders and tūpuna (ancestors) such as Te Puea Hērangi¹, this project aimed to prepare and protect Māori communities to ensure the health and wellbeing of future generations through informed and supported decision-making in health settings.

Background

Māori have over 200 years of colonial history that continues to impact Māori health and overall outcomes today. Māori persistently experience significant health inequities across multiple indicators compared to non-Māori in Aotearoa New Zealand (Health New Zealand, 2024b). These outcomes can be characterised across multiple dimensions, including system-level inequities, inequitable access to sufficient healthcare, disproportionate exposure to health risks, societal marginalisation, and inadequate representation in the healthcare workforce (Reid et al., 2019; Waitangi Tribunal, 2023).

The development of Raakai was guided by the histories and proverbial sayings of the Kiingitanga² (Māori King Movement). The Kiingitanga formed in the 1850s as a pan-Māori response to colonisation and Māori land confiscation, that aimed to unify iwi and create a

¹ Te Ara NZ biography Te Puea Hērangi

² Te Ara NZ Kiingitanga

Māori authority equivalent to the British Monarch (King, 2003). In 1907, the New Zealand Government banned the traditional Māori practices, rituals and knowledge of tohunga (experts) through the Tohunga Suppression Act 1907 (Hokowhitu et al., 2022). Through this legislation, the Crown aimed to replace rongoā Māori (traditional medicinal practices) with Western medicine. However, early 20th Century healthcare services in Aotearoa provided little to no access for Māori communities during this time (King, 2003; Stephens, 2001). The Act has had a lasting impact on Māori health outcomes, contributing to Māori reluctance to engage with Western healthcare settings and other government agencies (Thompson et al., 2024).

Of significance to Raakai is the impact of diseases introduced to Aotearoa on Māori health outcomes during the early 1900s, including smallpox, measles, whooping cough, and influenza (King, 2003). Māori in the Waikato area were at risk of complications or death from diseases introduced by Pākehā (European New Zealanders) because of hospitals and healthcare workers refusing to provide healthcare to local Māori. Kiingitanga leader Te Puea Hērangi responded by developing makeshift hospitals and isolation huts in Mercer¹ for those who were unwell, successfully isolating the small-pox outbreak and ensuring no one died (King, 2003). For the people of Waikato, the legacy of Te Puea and her aspirations for a Māori hospital continue through the development of Ngā Miro Health Centre in Ngāruawāhia established in 1991 (Healthpoint, 2024). Today Ngā Miro provides GP and primary care services designed around the needs of Māori communities, incorporating both Western medical practices with Māori models of health (Raukura Hauora o Tainui, 2024).

When the COVID-19 pandemic hit Aotearoa in 2020, Māori communities across New Zealand galvanised a response to ensure the well-being and safety of all. During the pandemic, the Māori King at the time, Kīngi Tūheitia Pōtatau Te Wherowhero VII was aware of the impacts of

previous infectious outbreaks, with many leaders recalling the fear and loss they experienced. Kīngi Tūheitia, alongside Tā Tumu Te Heuheu, the paramount chief of Ngāti Tūwharetoa, called for everyone to take up the COVID-19 vaccine to “protect their whānau and their whakapapa (genealogy and interconnected relationships)” (Radio New Zealand, 2021, 0.23).

Learnings from the COVID-19 pandemic highlight the effectiveness of community and Māori-led immunisation initiatives and solutions in closing immunisation rate gaps between Māori and non-Māori (McMeeking et al., 2020). However, data since 2020 points to a decline in immunisation uptake, in particular Māori and Pacific childhood immunisations, that was exacerbated during the pandemic (Manatū Hauora, 2023). Raakai applied a kaupapa Māori approach that recognises the Tainui waka rohe (confederated tribal region) and represented the regional boundaries used by Health New Zealand for the Counties Manukau and Waikato. This article provides a synthesis of the insights gathered from across all Raakai data collection, offering analysis about immunisation thinking, behaviours and contexts aiming to inform and support decision-making in the health settings around immunisation.

As of 2025, childhood immunisation coverage among tamariki Māori remained significantly below the national target of 95% fully immunised by 24 months. Persistent disparities in immunisation uptake indicate ongoing inequities in access to and engagement with immunisation services, particularly among Māori populations and in regions with historically lower coverage rates (Health New Zealand, 2025, 2025a, 2025b). Research literature identifies trends of structural inequity as opposed to individual hesitancy or choice, with longstanding breaches of Te Tiriti o Waitangi³ evident across primary care and immunisation services (Brown et al., 2021; Jansen et al., 2009; Ministry of Health, n.d.; Walker et al., 2019; Wehipeihana et al., 2022).

Charania et al. (2024) found that attitudes to vaccination indicate that many Māori parents

³ Te Tiriti o Waitangi is the Māori language treaty signed between Māori chiefs and the Crown in 1840. Assuring Māori having undisturbed possession and

authority over their lands, forests, fisheries, and all treasures including wellbeing, however, the treaty was continually breached by the Crown.

view immunisation as a social norm and value its protective benefits, yet their interactions with services are often characterised by racism, coercive, or deficit-based communication. Brown et al. (2021) note that some whānau and māmā (mothers) describe procedural, coercive, and deficit-focused engagement from healthcare providers including shame-based tactics that undermine mana motuhake (Māori self-determination).

The COVID-19 pandemic saw a decline in childhood immunisation uptake, with coverage for tamariki Māori falling from 87% to 69% (Charania et al., 2024). Reasons for such decline include the presence of barriers to effective immunisation services and support that are multilayered and include; a lack of transport, cost and time pressures, unstable housing, incorrect contact details, inflexible hours, cultural unsafety, and poor-quality information or dialogue about vaccines (Brown et al., 2021; Charania et al., 2024; Lee et al., 2020; Walker et al., 2019).

While systemic barriers persist, literature also highlights the effectiveness of Māori and Indigenous-led approaches to immunisation service and uptake. In Māori contexts, this includes the prioritisation of relationship-building and establishing trust with whānau, utilising holistic health models, and embedding service delivery with whānau-centred and whānau-led approaches (Immunisation Advisory Centre, 2024; Wehipeihana et al., 2022). Additionally, Brown et al. (2021) report that several Māori māmā are not opposed to tamariki vaccinations but instead are uncomfortable with coercive relations by practitioners that undermine mana motuhake and informed decision-making. Increased satisfaction and improved outcomes for whānau Māori are evident in healthcare approaches that incorporate cultural elements such as tikanga (protocols), rongoā, mātauranga Māori (Māori knowledge), and culturally appropriate engagement (Brown et al., 2021; Charania et al., 2024; Jansen et al., 2009; Wehipeihana et al., 2022).

Although Māori-led approaches and service delivery can be effective, outcomes are still largely dependent on the broader New Zealand health system and system-level barriers (Brown et al., 2021; Wehipeihana et al., 2022). Moreover,

funding allocations from the government continue to lack transparency and stability for providers, long-term contracts, and Māori representation in decision-making roles (Came et al., 2022; Wehipeihana et al., 2022; Waitangi Tribunal, 2023).

Advocates and researchers have called on the New Zealand government to uphold its Te Tiriti o Waitangi responsibilities to provide a health system that prioritises Māori health aspirations and health equity generally (Beri, 2019; Brown et al., 2021; Clark et al., 2020; Jansen et al., 2009; Ministry of Health, n.d.; Waitangi Tribunal, 2023; Walker et al., 2019). There is also a call for further research on kaupapa Māori and Māori-led immunisation initiatives and approaches with a view to share what works to engage whānau and potentially raising childhood immunisation rates for tamariki Māori (Brown et al., 2021; Wehipeihana et al., 2022). We suggest that research and evaluation opportunities that elevate mātauranga Māori can provide holistic insights and solutions for whānau Māori and is a critical area of health and social investment.

Research and Evaluation Methodology

The Raakai team drew off kaupapa Māori evaluative and research methodologies (Cram, 2018, 2024; Katoa, n.d). This approach was designed and delivered by Māori, for Māori, and with Māori, grounded in mātauranga Māori, tikanga (protocols), and language (Smith, 2022). We prioritised Māori concepts and tikanga such as whanaungatanga (process of relationship building), manaakitanga (hospitality), aroha (love), and utu (reciprocity) throughout (Wilson et al, 2021). This approach assumes the validity of Māori knowledge and is positioned within the context of Māori living in a colonised Aotearoa New Zealand (Smith, 2022). Our methodology ensured we critically reflected on the learning, development, discovery and collaboration that became evident working with providers in the project (Cram, 2018). This in turn led to action-reflection continuous development improvement. Critical to the approach was the need to ensure key relationships were developed and nurtured through strong alignment with kaupapa Māori methodology.

The Raakai project included a review of childhood immunisation services, approaches, and initiatives in the Counties Manukau and Waikato regions within an historical and place-based context. A clinical and community mātanga rōpū (expert group) supported and guided Raakai. The group included leading Māori healthcare practitioners, doctors, nurses, and midwives and local iwi leaders and kaimahi (workers). Mātanga members provided sector and community experience and expertise to the project, ensuring that Raakai remained aligned to the overall aims and values of the kaupapa. Mātanga supported the Raakai team to appropriately engage with iwi and hauora providers. A small group of mātanga members, and a team of emerging rangatahi (youth/young people) researchers completed qualitative and quantitative data collection, leading to a good proportion of the insights contained in this article.

Project locations and participants.

A survey was developed to better understand whānau perspectives on childhood immunisation and what may be important to them about how services are delivered. Questions related to the geographic location and iwi affiliation of respondents in order to enable researchers to report data appropriately. While the geographic focus of the project was in the Counties Manukau and Waikato regions, the research team recognised opportunities to engage Māori at a range of nationally significant events such as Te Matatini (national Kapa Haka team performance competition) and the Kiingitanga Regatta.

Our team developed relationships and initiated several collective gatherings with and for diverse Māori to share their insights around their immunisation activities. For example, we engaged directly with whānau of a marae and health provider in Counties Manukau, while also building the kaupapa Māori research and evaluation capacity of two kaupapa Māori health providers. In each of these instances we were given consent to use their insights about the delivery of their health services through a Māori approach. Interviews at a Hapū Māmā Wānanga (pregnant mothers learning forum) were also organised, alongside a hui ā-Rohe (regional meeting), which enabled Māori healthcare practitioners, nurses, midwives, doctors, and

frontline kaimahi to share their experiences of Māori vaccination issues. This regional meeting was also an opportunity for sense making and collaborative development of strategic enablers.

Survey findings

A total of 1,276 respondents completed the Raakai survey between February and August 2025 providing valuable insights into whānau perspectives and experiences regarding childhood immunisation. Examining responses through both the Tainui waka rohe and Waikato health service boundaries strengthens the ability to connect Raakai project findings with existing iwi and Health New Zealand datasets, and a more locally grounded understanding of whānau experiences.

Iwi and whānau profiles.

Many respondents were closely connected to the Tainui waka and its communities. Approximately 41% (n=525) resided within the Tainui waka rohe, encompassing Waikato, South Auckland, Hauraki, and the northern areas of the Manawatū-Whanganui region. More than half of all respondents 54% (n=689) identified whakapapa connections to the Tainui waka through affiliations with Waikato, Hauraki, Ngāti Maniapoto, or Ngāti Raukawa iwi. A group 41% (n=518) lived within the former Waikato District Health Board boundaries.

The survey was predominantly completed by caregivers of older tamariki. When asked about the age of the youngest child in their care, 67% (n=853) reported that their youngest tamaiti was aged two years or older. The most frequently reported age groups were six years and over (16%), five years (14%), and four years (13%). In contrast, the 18-month age group accounted for the smallest proportion of responses (4%) indicating that whānau caring for tamariki under two years of age were less represented in the survey.

Service perceptions, experiences and expectations.

Whānau perspectives on immunisation reflected diverse experiences and beliefs. Most respondents expressed positive views towards childhood immunisation, with 75% (n=960)

considering it important and 76% (n=975) feeling encouraged to make their own informed decisions. However, 11% (n=146) indicated immunisation was not important to them and nearly half of this group (47%) reported experiencing barriers to access.

Most respondents 83% (n=1,064) reported no barriers to accessing immunisation services. However, access alone did not determine uptake. While 14% (n=185) experienced barriers, a further 16% (n=205) chose not to immunise despite reporting none. Importantly 69% (n=879) felt their decisions were respected. Trusted relationships played a central role in decision-making. Wider whānau were the most trusted source of information 24% (n=740), followed by Māori health providers and practitioners 23%, friends 21%, and kaumātua 21%. Respondents also prioritised culturally safe and relationship-based care. Friendly staff (56%) Māori staff with established relationships (55%) te reo Māori-speaking staff (39%), and access to Māori staff generally (39%) were all seen as important elements of service provision.

Whānau who are uncertain.

Of the 146 respondents who stated childhood immunisation is not important to them, 47% reported some kind of barrier to immunisation and may or may not have gone on to immunise. This subgroup of whānau expressed uncertainty or hesitancy towards immunisation. Compared with the overall respondent cohort, these whānau reported lower levels of support, reduced access to information and services, and fewer experiences of having their choices acknowledged and respected. More than half of respondents within this group indicated that they did not feel encouraged to make informed decisions about immunisation (61%), and over two-thirds reported that their decisions were not respected by health providers or services (68%).

When asked about barriers to immunisation, access to reliable information emerged as a significant challenge. A 60% majority of uncertain whānau reported that being able to access the information they needed about immunisation was important, while 26% described having little or no access to information. Opportunities for meaningful

dialogue were also limited. Just over half of respondents (57%) reported being able to talk with someone about immunisation, while only half felt able to share their concerns 50%. Fewer than half (42%) reported that their questions about immunisation had been adequately answered.

Access to services was also constrained. While 57% reported being able to access immunisation services, only 53% considered them culturally appropriate. Together, these findings suggest that whānau who are uncertain about vaccinations experience a combination of information, relationship, and service barriers. They highlight the importance of culturally safe, whānau-centred approaches that support informed decision-making and respect whānau autonomy.

Whānau who choose not to immunise their Tamariki.

Of the 1,276 survey respondents, 16% (n=205) reported that they had not experienced barriers to immunisation access and had chosen not to immunise their tamariki. More than half 56% reported turning to whānau, kaumātua, and friends when seeking support or discussing immunisation. Most of these whānau (74%) felt supported in making their own decisions, and over half (57%) felt their choices were respected.

Decisions in this group appeared to be influenced more by beliefs, values, and trust than by service access. Nearly half (47%) reported that they did not believe in immunisation, 29% felt immunisation was being imposed upon them, 21% preferred alternative approaches to health and wellbeing, 18% were concerned about side effects, and 12% distrusted immunisation providers. A small proportion (5%) reported relying on rongoā Māori. Notably, only 3% identified a lack of information or unanswered questions as influencing their decision. These findings highlight the importance of engaging with whānau through trusted relationships, culturally safe approaches, and respectful dialogue that acknowledges diverse health beliefs and sources of knowledge.

Māori health provider insights

The Māori health provider in Counties Manukau highlighted that their kaupapa Māori, marae-based model fostered trusting relationships, which led to holistic whānau-led support. We worked with 12 whānau and 5 kaimahi from this provider to better understand how health venues, home visits, and community events created multiple pathways into trusted care. In general, whānau reported that they valued the accessibility of services, genuine support from kaimahi, and the opportunity to make informed decisions in their own time.

Kaimahi reported that despite systemic challenges such as short-term contracting, the service demonstrated a strong community-care orientation that prioritised relationship building and long-term engagement. Findings from engaging with this provider suggest that immunisation is more effectively supported through ongoing relationships rather than one-off initiatives.

Insights from Hapū Māmā Wānanga

Meetings called Hapū Māmā Wānanga, provided culturally grounded spaces for expectant parents and whānau to discuss pregnancy, parenting, and childhood immunisation. In this context we interviewed 29 whānau collectives participating in this forum. Whānau participants reported wanting accurate, accessible, and balanced information, with many feeling insufficiently informed to make confident decisions. COVID-19 experiences were frequently linked to reduced trust in health institutions, while renewed engagement with rongoā Māori and mātauranga Māori was described as strengthening whānau wellbeing. Some participants reported experiences of pressure and coercion within health settings, reinforcing concerns about autonomy and informed choice. Many encouraged others to seek trusted advice and make decisions aligned with their whānau values and aspirations.

Insights from Hui ā-Rohe

A Hui ā-Rohe (area based gathering) brought together 18 Māori healthcare workers from

Counties Manukau and Waikato to share approaches, challenges, and solutions for improving Māori health outcomes and tamariki immunisation. Participants emphasised that whānau-centred, Māori-led approaches are essential, highlighting the need to empower whānau through clear information, genuine choice, and shared decision-making, alongside co-designed services reflecting their lived realities.

Key barriers included cultural unsafety, funding instability, leadership changes, misinformation, and wider inequities. Strong support emerged for “by Māori, for Māori” solutions such as rangatahi-led initiatives, whānau, hapū, and iwi champions, and whole-of-whānau care, as well as delivering trusted information through hui and wānanga to strengthen health literacy. The hui also highlighted the importance of collective strength, resource sharing, and ongoing networking among providers to sustain place-based responses. Recommendations included prioritising Māori-led governance, investing in culturally safe, whānau-centred models, supporting kaimahi training, and strengthening collaborative networks led by whānau, hapū, and iwi.

Findings

The findings on childhood immunisation rates for tamariki Māori in the Counties Manukau and Waikato regions have implications for New Zealand health and policy. Analysis of the literature, survey responses, Hui ā-Rohe, interviews, and evaluative hui with a Māori health provider generated four interrelated themes.

Theme 1: Whānau value choice and relational trust. Whānau Māori emphasised that immunisation decisions depend on agency, respectful relationships, and access to te ao Māori and holistic supports (Anderson et al., 2026; Durie, 1985; Reweti, 2023). Significantly 75% of survey participants considered immunisation important, felt encouraged to decide for themselves, and reported that their decisions were respected. This reflects Māori health literature identifying manaakitanga, whanaungatanga, and tino rangatiratanga as essential to effective services, while warning that deficit-based or directive approaches undermine

engagement (Came et al., 2019). Hui ā-Rohe participants similarly viewed whānau-centred, Māori-led approaches as essential to trust and informed choice, rather than simply increasing uptake.

It's all about the whānau, not just one person. We get referred one person, but when we go into the home, [we get to know] the whole whānau, you know, that are in the whare. (house). (Māori provider kaimahi)

So I give whānau information that the Ministry of Health provide for them to make an informed choice. I give them the links to the Ministry of Health website so they can do their own rangahau (research) and make their own decision. I'm not an ant- vaxxer [sic]. I'm all about the choice of the individual and the whānau. (Hapū Māmā Wānanga facilitator)

Trusted relationships, face-to-face discussions, and marae-based settings enable whānau to consider immunisation alongside wider aspirations for their tamariki (Brown et al., 2021). Whānau therefore value care that is respectful and relational, rather than transactional.

Theme 2: Kaupapa Māori, marae-based and by-Māori models work. The Māori Provider Health venue and Hapū Māmā Wānanga demonstrate how kaupapa Māori and marae-based services apply principles supported by Māori health literature. Māori health promotion and primary care are more effective when place-based and grounded in local tikanga and kawa (Cram, 2018, 2024; Pīpi et al., 2004). Māori-governed services with long-term, flexible funding are also better positioned to build trust, respond to local realities, and sustain immunisation engagement (Cram, 2018).

Whānau reported ease of access, genuine support from kaimahi, and the opportunity to make informed decisions without pressure. Hapū māmā wānanga participants described moving from default compliance towards whakapapa-based decision-making, supported by wānanga and rongoā Māori. Hui ā-Rohe participants called for more “by Māori, for Māori” solutions, including marae-based hubs, rangatahi-led initiatives, and whānau, hapū, and iwi champions:

My young [tamaiti is neurodivergent]. That's why I need vaccinations in my home. I feel safe. (Māori provider whānau)

Our local provider Tūhono are so accommodating for health services in our community. They are even open on Saturdays. And late nights some days as well. And it's only a koha (donation). (Survey respondent)

Theme 3: Coercion, systemic and structural barriers persist despite apparent access.

Although most survey respondents reported no barriers to immunisation, our analyses revealed a complex picture of trusted access. Whānau in the Tainui area reported lower barrier-free access, while vaccine-hesitant whānau reported less support and respect. Everyday barriers included transport, limited local clinics, delayed birth registration, difficulty enrolling with GPs, and limited appointment availability. These findings reflect national and international evidence on Indigenous immunisation inequities (Koppaka et al., 2023; Ndubuka et al., 2026; Ryan et al., 2026; Young et al., 2026). Timely primary-care enrolment is strongly associated with childhood immunisation uptake, yet Māori children experience inequities in enrolment and access to vaccination services. Administrative complexity, limited resources, inconvenient clinic hours, and a lack of culturally appropriate services can delay or prevent immunisation (Ryan et al., 2026). A Māori health provider kaimahi described how delays in birth registration and National Health Index enrolment can also prevent whānau from accessing care early, even when strong relationships exist:

I think a barrier for some of our whānau is they don't get their birth certificate in time, so they're not enrolling with the GP, but then I guess that's where we're very lucky where we can refer them to the [health provider service] so that they don't miss their first six-week imms [sic]. (Māori Provider kaimahi)

More services in our community will be helpful. We have a lot of kaumātua, rangatahi and families without transport. (Survey respondent)

Hui ā-Rohe participants identified funding instability and siloed contracts as structural constraints on sustainable, relationship-based services. Coercive, one-way, and transactional care can further undermine engagement (Ryan et al., 2026; Young et al., 2026). Whānau described pressure and conditional care:

Imms [sic] is forced on us. (Survey respondent)

If I take my baby into the drs, because he's sick. They won't let me leave if my baby's overdue for his vaccinations. I feel pressured. (Survey respondent)

These experiences reflect institutional racism and colonial power dynamics in which Māori may feel silenced, overruled, or judged when their decisions differ from biomedical expectations (Came et al., 2019). Practitioners linked these experiences to target-driven contracts, staff turnover, limited Māori governance, and funding models that prioritise short-term outputs over relationship-building. The label “vaccine hesitant” may also individualise what is fundamentally a structural and relational issue. Access depends not only on whether a clinic exists, but on whether funding and health infrastructure systems reflect diverse whānau realities.

Theme 4: Diverse Māori-centred decision-making pathways. Some whānau who do not immunise are influenced by beliefs that immunisation is unnecessary, concerns about coercion, and preferences for rongoā Māori. Māori health decision-making is shaped by coloniality, intergenerational experiences, whānau knowledge, and holistic understandings of wellbeing (Pihama et al., 2014). Māori models emphasise the interconnection of wairua (spirit), whānau, whakapapa, whenua (land), and tinana (physical body) meaning health interventions are interpreted within cultural, spiritual, and relational contexts (Reweti, 2023; Wilson et al., 2021):

My grandmother does rongoā Māori, so I haven't prioritised imms [sic]. (Survey respondent)

Our bodies produce what we need to overcome. (Survey respondent)

Let's engage deeply in wānanga and share the knowledge that lives within us. There are still Māori solutions, Māori knowledge that can resolve the illnesses we face. (Hapū Māmā Wānanga interviewee)

Hapū Māmā Wānanga narratives framed whenua, (land) atua (god/gods), and rongoā as positive sources of protection and wellbeing, rather than rejection of healthcare. Hui ā-Rohe participants advocated for approaches that respect rongoā,

validate whānau expertise, and create space for whakawhanaungatanga (creating new relationships), dialogue, and informed decision-making.

Overall, whānau Māori make immunisation decisions within broader Māori worlds, not solely biomedical frameworks. Respectful, culturally safe, whānau-centred relationships are essential, while directive or impersonal communication can undermine trust. New Zealand and international Indigenous research similarly identify cultural safety, community ownership, local leadership, and relationship-based care as important foundations for engagement and improved immunisation outcomes (Curtis et al., 2019, 2025; Ndubuka et al., 2026; Young et al., 2026).

Discussion

The Raakai project contributes to evidence that tamariki Māori immunisation coverage reflects structural inequities and health-system design, rather than information deficits or individual parental reluctance. Most whānau regarded immunisation as important and felt generally encouraged and respected, yet coverage gaps remain for Māori in Counties Manukau and Waikato. This aligns with literature identifying inequities in the organisation, funding, and culture of health services, breaches of Te Tiriti o Waitangi and institutional racism (Came et al., 2019; Curtis et al., 2025; Graham & Masters-Awatere, 2020). The Waitangi Tribunal (2019) found that the Crown breached Te Tiriti by failing to design a primary healthcare system that actively addresses persistent Māori health inequities. Addressing power imbalances through trust building activities, reciprocity, and shared decision-making, while moving away from deficit explanations of “non-adherence,” is central to reducing these inequities (Graham & Masters-Awatere, 2020).

Around three quarters of respondents regarded childhood immunisation as important and felt encouraged to decide for themselves. Hui, interviews, and wānanga emphasised the importance of time, face-to-face kōrero, and respect for whānau and intergenerational knowledge. This mirrors Brown et al.'s (2021) kaupapa Māori study, which found that trust

depends on who delivers information, their perceived agenda, and whether whānau feel judged. Our findings illustrate that pressure, conditional care, and shame-based communication erode trust and may push whānau away from services, even when they are not opposed to vaccination. International evidence similarly links culturally unsafe and transactional healthcare with reduced Indigenous vaccination programme engagement (Bruno et al., 2022; Rigney et al., 2022; Ryan et al., 2026). Providers and funders should therefore shift from target-driven engagement towards models based on whanaungatanga, manaakitanga, and tino rangatiratanga (Parata et al., 2021).

Kaupapa Māori, marae-based, and by-Māori models, including the Māori Health Provider and Hapū Māmā Wānanga, demonstrate this approach in practice. Whānau reported easier access, genuine support from kaimahi, and space to consider immunisation alongside broader aspirations for tamariki and whānau wellbeing. Long-standing, community-embedded relationships similarly supported collaborative immunisation decision-making in a Taranaki case study (Parata et al., 2021).

Access to rongoā Māori alongside Western interventions, and care in familiar cultural settings, appeared to strengthen trust and create multiple pathways into care. This reflects evidence that Māori and Pacific whānau may view rongoā and Western medicine as complementary (Reweti, 2023; Wilson et al., 2021). Sustained investment in Māori-led, place-based services is therefore needed, with funding and accountability structures that value long-term relationships over short-term outputs.

Structural barriers persist beneath surface measures of “access.” Although most respondents reported no barriers, subgroup and qualitative data identified delayed birth registration, enrolment difficulties, transport challenges, limited appointments, and geographic service gaps. These issues were particularly evident among whānau in the Tainui waka rohe and vaccine-hesitant respondents, who reported less support and respect than the overall sample. “Access” should not simply equate to clinical availability, but also include how well systems

accommodate whānau circumstances, including mobility, housing precarity, caring responsibilities, and cultural expectations.

Whānau experiences of coercion echoed practitioner accounts of target-driven contracts, staff turnover, and limited Māori governance. These conditions reproduce power imbalances by prioritising predefined goals over services shaped by whānau priorities and mātauranga. Western-centric funding and measurement frameworks continue to constrain “by Māori, for Māori” approaches despite their demonstrated effectiveness (Waitangi Tribunal, 2023). Future work should partner with whānau, iwi, and Māori providers to extend and resource place-based models that prioritise relationship-building and broader whānau health.

Limitations

The survey sample, while substantial (n=1,276), was self-selecting. Whānau already connected with Māori health providers or Hui ā-Rohe networks may be over-represented, while those with little or no service contact may be under-represented. Findings may therefore understate barriers and enablers. The insights shared here are specific to the Tainui waka rohe and should be applied cautiously to other iwi and regions.

Conclusion

Raakai demonstrates how iwi, Māori providers, and whānau can co-produce evidence and solutions through a place-based, kaupapa Māori holistic approach to health. The project shows that kaupapa Māori, marae-based, and by-Māori, for-everyone services can provide safe, relational pathways into immunisation alongside wider aspirations for tamariki and whānau wellbeing. Most participating whānau valued immunisation and felt encouraged to make their own decisions.

Persistent coverage inequities nevertheless reflect structural barriers, coercive and culturally unsafe practices, and health-system settings that privilege short-term targets over sustained relationships.

Aotearoa New Zealand’s immunisation landscape remains shaped by colonisation, systemic racism, and breaches of Te Tiriti o Waitangi. Decision-makers have an opportunity

to invest in Māori governance and leadership, stabilise relationship-based funding, and redesign accountability mechanisms so Māori providers are resourced to deliver approaches informed by their communities.

Methodologically, Raakai demonstrates the strengths of kaupapa Māori evaluation within a large-scale, mixed-methods immunisation study. Iwi networks, marae-based engagement, and a mātanga rōpū grounded the research in local histories, Kīngitanga tongikura, and Māori concepts of wellbeing.

Glossary

Aotearoa	Māori name for New Zealand.
Aroha	Love.
Atua	God/gods.
Hapū	Sub-tribe; a kinship group that descends from a common ancestor. Can also be used to describe someone who is pregnant.
Hapū Māmā Wānanga	Pregnant mothers learning forum
Hauora	Holistic concept of health, encompassing physical, mental, spiritual, and family/social wellbeing.
Hui	Gathering or meeting.
Hui a rohe	Area based gathering.
Iwi	Tribe; a large kinship group linked by genealogy.
Kaimahi	Workers.
Kaitiaki	Guardian/guardians.
Kaumātua	Elders or senior members of a whānau, hapū, or iwi who provide cultural leadership and guidance.
Kaupapa	Underlying purpose or guiding principle

Kaupapa Māori	of an initiative or project. By-Māori-for-Māori research or evaluation grounded in Māori knowledge, tikanga, language, and aspirations.
Kawa	Māori protocol and formal customs observed on the marae.
Kīngitanga	The Māori King Movement, established in the 1850s to unify iwi and uphold Māori authority.
Kōrero	Talk, discussion.
Koha	Donation
Māmā	Mother or mothers.
Mana	Inherent authority, power, and dignity.
Manaakitanga	Hospitality.
Mana motuhake	Self-determination and autonomy over Māori lives and resources.
Marae	Meeting place and complex that functions as a cultural, social, and often service-delivery hub.
Mātauranga Māori	Māori knowledge systems, including values, practices, and ways of understanding health and wellbeing.
Mātanga rōpū	Expert group
Pā	Māori settlement.
Pākehā	European New Zealanders.
Pēpi	Māori term for baby/babies or infant/infants.
Pou tikanga	Māori cultural supervisor/advisor
Rangahau	Research.

Rangatahi	Youth/young people.	Whakapapa	Genealogy and interconnected
Rangatira	Chief/leaders.		relationships that
Rongoā Māori	Traditional Māori healing practices, such as plant-based remedies, mirimiri (traditional massage), and karakia (incantations/prayers).	Whānau	Family and extended family networks, including kin and sometimes close non-kin who function as family.
Rohe	Tribal region.	Whānau Māori	Māori family or families. In the Māori language, adjectives follow the noun they describe.
Tainui waka	Ancestral canoe that arrived in Aotearoa; associated confederation of iwi whose rohe includes Counties Manukau and Waikato.	Whanaungatanga	Processes of relationship building
Tainui waka rohe	Confederated tribal region of Tainui.	Whakawhanaungatanga	Process of creating new relationships
Tamariki / Tamaiti	Tamariki: children (plural). Tamaiti: child (singular).	Whenua	Māori term used for land. Can also be used as a term for placenta.
Te Ika-a-Māui	North Island of New Zealand.		
Te Niwha	New Zealand's national infectious diseases research platform.		
Te Tiriti o Waitangi	Māori-language treaty signed in 1840 between Māori chiefs and the Crown, affirming Māori authority and guaranteeing self-determination.		
Te reo Māori	The Māori language.		
Te Matatini	National kapa haka team performance competition.		
Tikanga	Māori customary values and principles that guide culturally appropriate behaviour.		
Tinana	Physical body.		
Tūpuna	Ancestor/ancestors.		
Utu	Reciprocity.		
Wānanga	Learning forum.		
Wairua	Spirit		

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