

Ūkaipō niho: the place of nurturing for oral health

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ABSTRACT

Objectives: To report on oral-health-related characteristics, beliefs, and behaviours among participants in a randomised control trial of an intervention to prevent early childhood caries (ECC) among Māori children, and to determine whether there were any systematic differences between the intervention and control groups at baseline.

Design: Baseline measurements from a randomised control trial (involving 222 pregnant Māori women allocated randomly to either Intervention or Delayed groups) which is currently underway.

Setting: The rohe (tribal area) of Waikato-Tainui.

Methods: Self-report information collected on sociodemographic characteristics, pregnancy details, self-reported general and oral health and health-related behaviours, and oral health beliefs.

Results: Other than those in the Delayed group being slightly older, on average, there were no significant differences between the two groups. Some 37.0% were expecting their first child. Most reported good health; 43.6% were current smokers, and 26.4% had never smoked. Only 8.2% were current users of alcohol. Almost all were dentate, and 57.7% described their oral health as fair or poor. One in six had had toothache in the previous year; 33.8% reported being uncomfortable about the appearance of their teeth, and 27.7% reported difficulty in eating. Dental service-use was relatively low and symptom-related; 78.9% needed to see a dentist. Overall, most of the sample believed that it was important to avoid sweet foods, visit dentists and to brush the teeth, while about half thought that using fluoride toothpaste and using floss were important. Some 38.2% felt that drinking fluoridated water was important. Oral-health-related fatalism was apparent, with 74.2% believing that most people usually get dental problems, 58.6% believing that most people will need extractions at some stage, and that most children eventually get dental caries.

Conclusions: Mothers' important role in nurturing the well-being of the young child includes the protection and maintenance of the growing child's oral health (or ukaipo niho). The findings provide important insights into Māori mothers' oral health knowledge, beliefs and practices.

INTRODUCTION

Early childhood caries (ECC) causes profound suffering, frequently requiring expensive treatment under a general anaesthetic (Malden et al, 2008). It is strongly associated with poor oral health in adulthood (Thomson et al, 2004). Marked ethnic disparities are apparent in countries such as Australia, New Zealand and Canada, where the prevalence and severity of ECC are higher in indigenous children than their non-indigenous counterparts (Parker et al, 2010). If the burden of ECC experienced by indigenous children in these nations is to be reduced, more needs to be done to ensure that appropriate preventive measures—together with support for maintaining optimal oral health—are undertaken with carers of such children in the early life stages.

Findings from the most recent national oral health survey have confirmed that Māori do not enjoy the same oral health (or access to routine dental care) as non-Māori (Ministry of Health, 2010). Māori mothers play the key role in the oral health of their children (Murchie, 1984), and this was reiterated by Dyall (1997), who stressed the crucial role of Māori women as fundamental agents of change in shaping the behaviour and values of the next generation. A community-based assessment of the oral health needs of Māori mothers in Porirua found not only substantial need, but that access to appropriate information, support and dental care was deficient. The dental system for adults was ineffective for Māori mothers, and its focus on relief of pain provided little opportunity for preventive dental care. The author identified a need for a community-based oral health service with a whānau approach and a preventive focus (Makowharemahihi, 2006). These findings were supported by those of a study of oral health research priorities for Māori (Robson et al, 2011). In recent years, a small number of oral health initiatives have targeted Māori women. In 1997, the Tipu Ora Charitable Trust (a Māori mother and child wellness provider in Rotorua) established a dental service for its client base of pre-school children. This service has subsequently developed with the provision oral health services for all age groups including mothers, care-givers and parents. In Northland, the Ngati Hine Health Trust and Hokianga Health have more recently developed specific oral health services for young mothers and caregivers.

Given their importance in ensuring oral health among tamariki Māori, it is somewhat curious that little is known of the oral health beliefs and oral-health-related behaviours of Māori women. The aim of this paper is to report on oral-health-related characteristics, beliefs, and behaviours among participants in a randomised control trial of an intervention to prevent ECC among Māori children, and to determine whether there were any systematic differences between the intervention and control groups at baseline.

METHODS

It is appropriate to commence with some background to the overall study. In 2009, three health research funding bodies (the National Health and Medical Research Council of Australia, the Health Research Council of New Zealand, and the Canadian Institutes of Health Research) called for expressions of interest from research groups for the international collaborative study. Reducing the burden of disease and inequalities in health arising from chronic disease in indigenous people. The successful application was from a coalition of researchers from the Universities of Adelaide, Otago and Toronto, and tribal organisations in Australia, New Zealand (Aotearoa) and Canada. In New Zealand, the study is being conducted as a research partnership between the University of Otago and the two Waikato-Tainui tribal entities, Raukura Hauora O Tainui (a major health and social service provider) and the Waikato-Tainui College for Research and Development.

The aim of the wider project is to determine whether implementation of a functional, context-specific ECC intervention (employing a tailored approach and drawing on a range of contexts including oral health promotion, oral health protection, dental disease prevention, oral health care and maintenance, dental systems navigation and oral health literacy) reduces the dental disease burden among indigenous preschool children living in Australia, New Zealand and Canada. It is an interventional study involving pregnant indigenous women residing in the three countries and their newborn children. It employs a randomised delayed intervention comparison design, with all participants ultimately receiving the intervention benefits. The intervention is implemented from birth and continues for the first three years of a participating child's life. The intervention involves four components: dental care provided to the mother during pregnancy; application of topical fluoride to children's teeth; anticipatory guidance¹; and motivational interviewing of mothers. Ethics approval for the New Zealand/Aotearoa arm of the study was obtained from the Northern Y

Regional Ethics Committee in September 2010. This is the Ethics Committee which is responsible for health research projects undertaken in the Central North Island. It was registered with the Australia New Zealand Clinical Trials Registry on 26 May 2010 (ACTR Number ACTRN12610000422022).

A sample size of 192 participants (96 per study arm; alpha = 0.05, 90% power to detect a difference) was calculated as being necessary to detect ECC incidence differences, based on reported ECC incidence among Indigenous children of 50–75% over two years. For convenience, this was rounded up to 200 participants; 100 in the intervention group and 100 in the delayed intervention group. Once the recruitment commenced, the total participant group was increased slightly to offset any attrition.

The research participants were pregnant Māori women who reside within the rohe (tribal area) of Waikato-Tainui in the central North Island. They were recruited by whaea, (respected Māori women) through the primary health care clinics operated by Raukura Hauora O Tainui. The whaea are responsible for maintaining contact with the participants through the duration of the study (along with a motivational interviewer who will contact the participants at 6, 12 and 18 months). Once recruited, the participants were randomly allocated to either the Intervention group or the Delayed Intervention group.

The baseline assessment of participants involved a questionnaire which sought information on sociodemographic characteristics, pregnancy details, self-reported general and oral health and health-related behaviours, and oral health beliefs.

Data were entered by the Research Administrator at the Waikato-Tainui College for Research and Development, then analysed using SPSS (version 20). After the computation of summary statistics, differences among means were tested for statistical significance using analysis of variance; Chi-square tests were used for differences among proportions.

¹ A pro-active, developmentally-based counselling technique that focuses on the needs of a child at a particular stage of life (Nowak and Casamassimo, 1995)

Table 1. Sociodemographic characteristics, by group (brackets contain row percentages unless otherwise specified)

Characteristic	Group		
	Intervention	Delayed	Both combined
Number	110 (49.5)	112 (50.5)	222 (100.0)
Mean age (sd)	25.1 (6.9)	26.9 (6.2) ^a	26.0 (6.6)
Education level (4 missing)			
Up to secondary schooling	42 (38.9)	43 (39.1)	85 (39.0)
Trade/Polytechnic	45 (41.7)	39 (35.5)	84 (38.5)
University	21 (19.4)	28 (25.5)	49 (22.5)
Household income source (20 missing)			
Job only	37 (37.4)	33 (32.7)	70 (35.0)
Job and benefit	11 (11.1)	10 (9.9)	21 (10.5)
Benefit only	51 (51.5)	58 (57.4)	109 (54.5)
Hold a Community Services Card (2 missing)	73 (67.0)	76 (68.5)	149 (67.7)
Household owns a car	65 (59.6)	67 (60.4)	132 (60.0)

^a P = 0.04

RESULTS

The recruited sample comprised 222 pregnant women, of whom 49.5% were allocated to the Intervention group, and 50.5% to the Delayed group (Table 1). Those in the latter were slightly older, on average, but there were no other significant differences between the two groups. Just over one-fifth had been educated to University level, with approximately equal proportions in those educated to secondary level or to trade/Polytechnic level. Just over half of the sample were in households where the income source was a benefit; one-third did not receive a benefit, and the remainder were supported by a combination of job and benefit. Two-thirds of the sample held a Community Services Card, and over half were in a household with a car.

Information on pregnancy and self-reported health and health behaviours is presented in Table 2. There were no significant differences between the two groups. Just over one-third were expecting their first child (an apparent difference between the two groups was not statistically significant). About one in seven had a chronic medical condition, and one in eight of the sample rated their general health as fair or poor. One-third had excellent or very good health. Just under half were current smokers, and about one-quarter had never smoked. One in 12 was a current user of alcohol, and just over one in ten had never used it.

Data on self-reported oral health and behaviours are presented in Table 3, and show no significant differences between the two groups. All but 10 were dentate, and over half described their oral health as fair or poor. In relation to the previous year, one in six had had toothache. One-third reported being uncomfortable about the appearance of their teeth, and one-quarter reported difficulty in eating. Dental service-use was relatively low, with just over one-third having visited in the previous year, and over half having been unable to do so due to cost. Over three-quarters reported that they needed to see a dentist, and just over one-fifth

would be apprehensive about visiting. More than half of the sample did not visit routinely for check-ups.

Data on the sample's beliefs about (and fatalism in respect of) oral health are presented in Table 4. There were no significant differences between the groups. Overall, most of the sample believed that it was important to avoid sweet foods, visit the dentist and to brush their teeth, while about half thought that using fluoride toothpaste and using floss were important. Just over one-third felt that drinking fluoridated water was important. The proportion of the sample who believed that they could not (or should not) do much about children's deciduous teeth was small, with about one in ten believing that they do not matter much because they fall out anyway, and even smaller proportions agreeing with the other statements. By contrast, a degree of oral-health-related fatalism was apparent in the majority of the sample, with three-quarters believing that most people usually get dental problems, and well over half believing that most people will need extractions at some stage, and that most children eventually get dental caries.

DISCUSSION

A well-known Māori proverb is "Papa-tū-ā-nuku te mātua o te tangata", which can be translated as "Mother Earth is the parent of mankind." In the context of this research project, this saying can be reflected in the important role of the mother in nurturing the well-being of the young child. This parental care also encompasses the protection and maintenance of the growing child's oral health, or ūkaipō niho. Our aim was to describe and compare sociodemographic and oral-health-related characteristics, beliefs, and behaviours measured at baseline among participants in a randomised control trial of an intervention to prevent ECC among Māori children. The overall

Table 2. Pregnancy details, self-reported general health and health-related behaviours, by group (brackets contain row percentages unless otherwise specified)

Characteristic	Group		
	Intervention	Delayed	Both combined
Expecting first child (3 missing)	47 (43.1)	34 (30.9)	81 (37.0)
Number of weeks pregnant (1 missing)	25.4 (9.5)	25.1 (8.7)	25.3 (9.1)
1+ medical conditions ^a	14 (12.7)	17 (15.2)	31 (14.0)
Self-rated general health (2 missing)			
Excellent/Very good	40 (36.7)	38 (34.2)	78 (35.5)
Good	56 (51.4)	58 (52.3)	114 (51.8)
Fair/Poor	13 (11.9)	15 (13.5)	28 (12.7)
Tobacco use (2 missing)			
Current	45 (41.3)	51 (45.9)	96 (43.6)
Former	39 (35.8)	27 (24.3)	66 (30.0)
Never	25 (22.9)	33 (29.7)	58 (26.4)
Alcohol use (2 missing)			
Current	10 (9.2)	8 (7.2)	18 (8.2)
Former	88 (80.7)	90 (81.1)	178 (80.9)
Never	11 (10.1)	13 (11.7)	24 (10.9)

^a Such as rheumatic fever, kidney problems, heart condition, diabetes or any other chronic condition.

Table 3. Self-reported oral health and oral-health-related behaviours, by group (brackets contain row percentages unless otherwise specified)

Characteristic	Intervention	Group	
		Delayed	Both combined
Dentate (2 missing)	103 (94.5)	109 (98.2)	212 (96.4)
Self-rated oral health (2 missing)			
Excellent/Very good	11 (10.1)	17 (15.3)	28 (12.7)
Good	32 (29.4)	33 (29.7)	33 (27.9)
Fair/Poor	66 (60.6)	61 (55.0)	127 (57.7)
Experienced the following impacts frequently in the previous year:			
Toothache	15 (13.8)	21 (18.9)	36 (16.4)
Trouble eating	25 (22.9)	36 (32.4)	61 (27.7)
Being uncomfortable about how teeth looked	42 (38.9)	32 (28.8)	74 (33.8)
Dental visit made in previous year (7 missing)	36 (33.6)	45 (41.7)	81 (37.7)
Unable to see a dentist in the previous year due to cost (3 missing)	67 (62.0)	64 (57.7)	131 (59.8)
Need to see a dentist now (4 missing)	86 (78.9)	86 (78.9)	172 (78.9)
Would be scared about visiting (2 missing)	15 (13.8)	25 (22.5)	40 (18.2)
Usually visit for check-up (7 missing)	41 (38.3)	42 (38.9)	83 (38.6)

Table 4. Oral health beliefs and oral-health-related fatalism, by group (brackets contain row percentages unless otherwise specified)

	Intervention	Group	
		Delayed	Both combined
Oral health beliefs			
<i>Believe it is important to:</i> ^a			
Not have a lot of sweet foods	74 (67.3)	84 (75.7)	158 (71.5)
Use fluoride toothpaste	60 (54.5)	52 (47.3)	112 (50.9)
Visit dentists	95 (86.4)	92 (82.9)	187 (84.6)
Brush teeth	109 (99.1)	107 (97.3)	216 (98.2)
Drink fluoridated water	47 (43.1)	37 (33.3)	84 (38.2)
Use dental floss	58 (52.7)	63 (57.3)	121 (55.0)
<i>Strongly or somewhat strongly agree with:</i> ^b			
Holes in baby teeth don't matter much because baby teeth fall out anyway	13 (11.8)	10 (9.0)	23 (10.4)
Keeping baby teeth clean is not very important because baby teeth fall out anyway	5 (4.5)	5 (4.5)	10 (4.5)
There is not much I can do to stop my child getting holes in their teeth	4 (3.6)	3 (2.7)	7 (3.2)
There is not much I can do to help my child have healthy teeth	1 (0.9)	2 (1.8)	3 (1.4)
Children don't need to brush every day until they get their adult teeth	2 (1.8)	2 (1.8)	4 (1.8)
Children don't really need their own toothbrush until all their teeth come	7 (6.4)	2 (1.8)	9 (4.1)
Oral-health-related fatalism			
<i>Strongly or somewhat strongly agree with:</i> ^a			
Most people usually get problems with their teeth	77 (70.0)	87 (78.4)	164 (74.2)
Most people will need to have their teeth pulled out sooner or later	61 (55.5)	68 (61.8)	129 (58.6)
Most children eventually get holes in their teeth	72 (65.5)	62 (55.9)	134 (60.6)

^a 2 missing ^b 1 missing

sample comprised a diverse mix of women from across the socio-economic range (that 61% of the participants had undergone tertiary studies yet 68% currently held a community services card may be due to many of the young mothers-to-be being on maternity leave during this time; moreover, many tertiary students also have a community services card). Most were in good health, with fewer than half being current smokers and very few currently using alcohol. Almost all were dentate, but more than half reported poor oral health, and dental visiting for most was sporadic and symptom-driven. The sample's oral-health-related beliefs were generally very sound (other than those related to fluoride), but a considerable proportion were fatalistic about oral health.

Before discussing the findings in detail, it is useful to consider the weaknesses and strengths of this study. Concerning the former, the baseline data are cross-sectional in nature, and so should be considered to be findings from a survey of pregnant Waikato-Tainui women. However, we are unable to comment on the generalisability of the findings because the women's recruitment by whaea through primary health care clinics means that the representativeness of the sample is unable to be determined. Paradoxically, the method of recruitment is also a strength of the study, because it has enabled the gathering of a sample of women who might not otherwise have taken part had the intention been to select a population-based sample (say, from the Electoral Roll) at the outset. Participation rates by Māori in conventional oral health survey research can be low (Robson et al, 2011). The direct involvement of Raukura Hauora O Tainui in the conception, planning, implementation and reporting of the study (as well as in kaitiakitanga in relation to the data) is a sound example of rangatiratanga in kaupapa Māori research (Broughton, 2006). Moreover, the personal and institutional relationships among the research team had been developed long before the project's inception, through links at personal, whakapapa and turangawaewae levels, and in previous productive research partnerships (Broughton et al, 2012). Notwithstanding the recruitment method, the randomisation process was effective in establishing equivalent intervention and delayed intervention groups. There was little evidence of any systematic differences in characteristics between the two groups, other than the Delayed group being slightly older, on average. This is reflected in there being little difference between the groups in their general and oral health status, and their views on oral health for themselves and their children.

The findings presented here provide an informative snapshot of the general and oral health (and related beliefs) of a group of women who are nurturing the next generation of Waikato-Tainui. The use of dental services in the previous 12 months was lower than that of the general population, and consistent with the Māori population utilisation rate reported in the New Zealand Oral Health Survey (Ministry of Health, 2010). Almost 60% of participants rated their oral health as fair to poor. This is a considerably higher proportion than reported in the NZOHS (2009) where 42% of Māori reported their oral health as fair to poor. Given that recent analyses of national survey data from New Zealand and Australia have offered support for the clinical validity of self-reported oral health (Thomson et al, 2012), these

findings give cause for concern. Moreover, the impact of the poor oral health of the primary caregiver on the child's oral health has been observed (Shearer et al, 2011; Shearer et al, 2012). This suggests that the first component of the proposed intervention (improving the oral health of the mother before the child is born) is likely to have a positive impact on the oral health of the child.

The findings underline the challenges (both personal and systemic) which face Waikato-Tainui (and Maoridom in general) and New Zealand society in improving the oral health of young children and their whānau (Te Amo, 2007). In an address to the Hui-A-Tau (annual conference) of Te Ao Mārama, the New Zealand Māori Dental Association, Dr Lorna Dyall said: "I think we need to recognise the power of our women as fundamental agents of change. We need to get alongside our present women because they will shape the behaviour of the next generation. If they value and look after their teeth, then the tamariki (children) will model that behaviour". This point effectively underlines the challenge, but it is not enough to focus merely on trying to change behaviour; wider changes are required (Sheiham and Watt, 2000), and these include enabling better access to oral health care for this under-served group of women and their families. This is exemplified by the finding that, on the one hand, 71.5% believed that it was important not to have a lot of sweet foods (and 84.6% believed that maintaining regular dental visits were important and 98.2% believed that brushing teeth was also very important); on the other hand, 78.9% currently needed to see a dentist, and well over half had been unable to visit a dentist in the previous year because of the cost. Whether there will be changes in the oral health fatalism data will make interesting watching over the course of the intervention study, because participating in a project designed to improve oral health might be expected to reduce that fatalism and increase maternal self-efficacy and optimism. Developing a culturally-appropriate ECC intervention that aims to improve child oral health will provide much needed evidence for policy makers to address the challenge of improved oral health and related outcomes for Indigenous children.

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GLOSSARY

Aotearoa	New Zealand
Hui-A-Tau	Annual conference
Kaitiakitanga	Stewardship
Kaupapa	Philosophy or principle
Mātua	Parent
Niho	Teeth, dentition
Papa-tū-ā-nuku	A primeval parent of Māori, the Earth
Mother	
Rangatiratanga	Chieftainship
Te	the
Tamariki	Child
Tangata	People
Tipu Ora	To grow in health, the name of a Māori health provider
Turangawaewae	Lit. a place to stand. An individual's traditional home base.
Ūkaipō	The place of nurturing
Ūkaipo niho	The place of nurturing for oral health
Waikato-Tainui	The name of a Māori tribal grouping
Whaea	Respected Māori woman
Whakapapa	Genealogy
Whānau	Family