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TE WHARE TANGATA: HOUSING, MATERNAL MENTAL HEALTH, AND WĀHINE MĀORI

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Kim Taylor and Waireti Roestenburg

SETTING THE SCENE

Those who live by original Māori lifeways recognise wāhine Māori as te whare tangata (the house of humanity); she is uniquely connected to Papatūānuku and symbolises life and fertility (Mikaere, 2003, 2011; Murphy, 2011; Pere, 2019; Roestenburg & Hoskyns, 2022; Yates-Smith, 2019b). Yates-Smith (2019b) explains, “Our ancestors considered the creative, fertile element to be the most important gift and, therefore, to be cherished” (p. 77). Wāhine, as bearers and carers of humanity, were treasured and held unique societal status (Pere, 2019; Roestenburg & Hoskyns, 2022; Roestenburg, 2023; Yates-Smith, 2019a). The reproductive role of wāhine was central to whakapapa, and, as Murphy (2011) notes, the very “survival of whānau, hapū, and iwi” (p. 26). Menstrual blood was revered for carrying the seeds of the tipuna-mokopuna continuum (Pere, 2019). This vital role granted wāhine privileged position in Māori society (Murphy, 2011; Pere, 2019; Roestenburg & Hoskyns, 2022). Tremendous respect was given to wāhine, especially during pregnancy (Pere, 2019; Roestenburg & Hoskyns, 2022; Yates-Smith, 2019a). As Pere, cited in Murphy (2011), affirms, “A mother cherishes and nurtures her child in the womb, and ... this cherishing and nurturing must continue” (p. 11). Violations of this sacred role, such as domestic violence or rape, were met with severe repercussions, including castration or death (Pere, as cited in Murphy, 2011).

The colonisation of Aotearoa New Zealand introduced a stark contrast between the inferior European status of women and the revered position of wāhine Māori, culminating in a reversal of Māori women's societal positioning (Pere, 2019; Pihama, 2001). Today, even while they continue to try and hold the sky up for their families and children, as the “‘house of the people’ (te whare tangata), many Māori women's reproductive bodies reflect [their] histories of colonial oppression and resistance” (Murphy, 2011, p. 13).

Too many wāhine continue to experience dispossession and intersecting challenges such as poverty, mental distress, violence, and racism (Durie, 2003; Jones, 2000; Smith et al., 2021). For young wāhine, their sexuality is stigmatised, stripping them of agency under narratives of “savagery” and “promiscuity” (Green, 2011; LeGrice, 2014; Reid, 2004). After becoming mothers, wāhine are more than three times as likely to die by suicide compared to other maternal groups in New Zealand (Productivity Commission, 2022). In sum, the current position of wāhine Māori, especially vulnerable or young mothers, could not be farther removed from their original societal positioning.

This project endeavours to illuminate the dark corners where the systemic dehumanisation of te whare tangata and her children thrives. Poignantly, this neglect is most evident in the realm of housing. Te whare tangata, the very house of humanity, faces continuing housing challenges that harm her and, therefore, the generations to come.

THE RESEARCH QUESTION

This project stems from the lead author's frontline mahi in the social service sector, where she has witnessed and continues to witness the housing desperation of too many mothers. Early in her role, she encountered a hapū wāhine who was unhoused, abstaining from drugs, and awaiting a court hearing. To ensure the health of her pēpi and avoid a prison-based pregnancy, she urgently needed a residential address to secure a community sentence. Although the Ministry of Social Development (MSD) agreed to place her on the social housing waitlist, she required immediate emergency housing. However, MSD advised that pregnancy alone does not qualify one for emergency housing—a provision available, though certainly not guaranteed, only once a child is born. The lead author's understanding of the social welfare landscape has since evolved. With her current knowledge, she would have advocated more vigorously, potentially challenging and demanding a review of that decision. The experiences of this māmā lie at the heart of this article, illuminating the human stories behind the data.

This witnessing of housing deprivation drives the central question of this inquiry: What is the most effective societal lever to address Māori perinatal distress and suicide? Both authors firmly believe that access to appropriate housing is crucial.

METHODOLOGY

This project undertakes a scoping review of quantitative and qualitative research to explore the intersections between maternal mental health (MMH) and housing with emphasis on perinatal wāhine Māori within the socio-political context of Aotearoa New Zealand. The review employs a broad-to-focused approach, beginning with general linkages between mental health and housing before narrowing to the specific experiences of Māori māmā.

Databases utilised include EBSCOhost, Elsevier, and PubMed. Keyword searches were “mental health and housing” and “maternal mental health and housing.” Variations of these terms included “Māori,” “health,” “Indigenous,” and “New Zealand.” The review incorporates 24 peer-reviewed sources, 11 of which are New Zealand-based, with the remainder primarily originating from the United States. These studies are particularly relevant due to the shared patterns of wellbeing disparities among Indigenous populations and ethnic minorities in settler-colonial societies such as the US, New Zealand, Canada, and Australia, where systemic inequities are often stratified along racial lines (Morris, 2023). Some consideration was given to older literature to track changes in housing and mental health patterns in New Zealand over time (James, 2007; Peace & Kell, 2001). Recognising the prominence of housing issues in public discourse, the review supplements its scholarly focus with material from reputable newspapers, magazines, and grey literature, including government policies and organisational white papers. These additional sources are integrated within the Discussion to provide a more comprehensive, homegrown understanding of the topic.

Before moving forward, we address our positioning of mothers as primary caregivers and our use of binary gendered language. First, a longitudinal study of families and whānau in New Zealand found that mothers handle over 90 percent of children's needs, even when fathers are present (Hennecke et al., 2020). Second, the majority of the lead author's tāngata whaiora (individuals seeking wellbeing) are single mothers, approximately 25 percent of whom are Māori. These women are the primary inspiration for this project. When referring to gender, the literature cited aligns with traditional terminology. In our Recommendations, we have purposefully used non-binary terminology to assure our proposal feels applicable to all.

Ethical considerations

The lead author, Taylor, a European descendant from a settler-colonial nation currently residing in another such nation, has reflected on her positionality throughout this project. Smith (1999/2021), in the introduction to *Decolonising Methodologies*, asserts that the term “‘research’ is inextricably linked to European imperialism and

colonialism” and is “one of the dirtiest words in the Indigenous world’s vocabulary” (p. 1). To engage responsibly, the lead author has embraced bi-cultural praxis, which includes education about te ao Māori, respect for tikanga, advocacy for Indigenous empowerment, and alignment with initiatives that uphold Māori aspirations (Came & Tudor, 2016).

The second author, Roestenburg, is a Māori woman, māmā, nana, academic, researcher, and facilitator of healing and learning wānanga. Waireti leads Te Wānanga o Te Wairua Māori where she delivers personal-collective, wairua-centric healing/learning and wellbeing promoting experiences in coproduction with Māori communities (Roestenburg et al., in press). She has played a central role in shaping this work. She has contributed both to the literature review and to the critical contextualisation of the research, ensuring it honours the ongoing realities, mana, and strength of te whare tangata. Her expertise has been invaluable in ensuring that Māori perspectives are authentically and respectfully represented.

A core principle of this project is that its objectives align with Māori aspirations, such as reducing wellbeing disparities in accordance with Te Tiriti o Waitangi (Paine et al., 2013). The Waitangi Tribunal’s 2019 findings of significant treaty breaches in the health sector led to the development of new policy tools to address these inequities (Came et al., 2023). Inspired by this approach, we situate this project within a similar Māori-centred framework with specific focus on housing.

FINDINGS

The bi-directional relationship between mental illness and lack of, or poor-quality, housing is well-established (Bovell-Ammon et al., 2020; Çaliyurt, 2022; Evans, 2003; Onapa et al., 2021; Patel et al., 2018). Stable, healthy housing provides a sense of control, lessens the chance of physical health problems, and provides an opportunity to develop social connections (Çaliyurt, 2022; Suglia et al., 2015). Onapa et al. (2021) examined nearly 30 international studies to conclude that proper housing can ease anxiety and depression. Studies have consistently proven that children who grow up in stable, healthy homes have better life outcomes than those who do not (Bovell-Ammon, 2020; DeCandia et al., 2022).

However, having a roof over one’s head is not a guarantee of good mental health. Evans (2003) explains that structural and environmental characteristics—“crowding, noise, indoor air quality, and light”—are profoundly important for psychological comfort (p. 536). Suglia et al. (2015) link aspects of housing to specific mental health outcomes. Structural problems can result in depression for adults and anxiety, behavioural issues, and delinquency in children. Frequent moves can lead to depression and anxiety in adults and scholastic problems for children. Patel et al. (2018) reiterate housing as a key determinant of social wellbeing, recommending fundamentals such as “affordable and clean energy,” structural and environmental integrity, and undercrowding (p. 1566).

Twenty-four years ago, Peace and Kell (2001) declared the need for a systematised, collaborative framework to address New Zealand’s interconnected housing and mental health difficulties. The tāngata whaiora interviewed expressed a desire for choice in housing location and type. Six years later, James (2007) detailed the impacts of inadequate housing on New Zealand children’s health. Challenges for young single mothers to secure rentals were highlighted, as was the “concerning substandard and poor-quality housing” in areas with high Māori populations (p. 11).

Analysing two decades of New Zealand research, Howden-Chapman et al. (2021) affirm that Māori, Pasifika, and those on a low income and/or with a disability are most negatively impacted by the country’s subpar, and dearth of, affordable homes. The connections between lack of housing and poor health, including MMH, for Māori mothers are well established yet remain unaddressed and are intensifying (Adcock et al., 2021). Māori were the primary subjects of colonisation in New Zealand. Today’s healthcare system extends from that history which explains factors behind lower medical service use amongst Māori (Durie, 2003). Māori face a higher likelihood of

encountering healthcare discrimination, receive inferior care, encounter premature hospital discharges, and are referred to specialists less frequently (Pitama et al., 2014; Wilson et al., 2021).

Māori women are more likely to experience depression, anxiety, stress, and poor mood during pregnancy than non-Māori (Signal et al., 2017). In their study of women and homelessness, Fraser et al. (2021) note that within a cohort of high government-service users, the majority were women (53.8 percent), younger (57.1 percent), Māori (78.6 percent), mothers (81.4 percent), and were 4.3 times more likely than the general population to need hospitalisation during pregnancy.

There are indications that depression in early motherhood is correlated with later housing insecurity, and depression is higher amongst mothers who lack personal and/or community support to navigate housing and other social concerns (Marçal, 2021). Peace and Kell in 2001 reported on the importance of housing location for Māori, who must often choose between living near whānau or living closer to community-based support services. This problem persists twenty years later (Adcock et al., 2021).

Suglia et al. (2011) found “housing disarray” (noisy, crowded housing) and instability (moving frequently) positively correlated with depression in mothers, and instability (but not disarray) correlated with generalised anxiety disorder (p. 1112). While they could not establish a direct connection between living in derelict housing and either depression or generalised anxiety disorder in mothers, other studies confirm that the type and quality of housing influences MMH. Evans (2003) cautions that “multiple dwelling units are inimical to the psychological well-being of mothers with young children” (p. 537). Such housing can exacerbate feelings of loneliness and lack of control, especially amongst those on low incomes (Evans, 2003; Suglia et al., 2015).

Reno et al. (2022) report that housing precarity and dereliction can negatively impact breastfeeding amongst mothers on a low income due to stress, mental health status, and/or pressure to return to work soon after childbirth. The housing concerns of study participants include a history of homelessness, fear of eviction, and domestic disorder. Although exclusive breastfeeding is recommended for the first six months of life, the authors found that housing insecurity was associated with a significant reduction in this practice. Reno et al. conclude that housing is a crucial determinant of health for mother and child, with race/ethnicity connected to housing status.

New Zealand studies concur that racial discrimination is connected to homelessness and poor-quality housing for pregnant and new mothers. Thayer and Kuzawa (2015) found that experiences of ethnic prejudice can increase stress in prenatal women and their newborn children via heightened cortisol levels. Bécares and Atatoa-Carr (2016) found that women who experienced racial discrimination in a health setting were 66 percent more likely to experience postnatal depression. Of the Māori, Pasifika, Asian, and European women analysed, Pasifika women had the highest rates of pre- and post-natal depression and prenatal stress overall, and Māori women had the highest reported incidences of discrimination, with nearly one-sixth of them having been verbally abused due to their ethnicity within the last year. In their study of 37 young wāhine mothers, Adcock et al. (2021) report that some reported experiences of racism in their search for private rentals.

Bécares and Atatoa-Carr (2016) identify housing as second only to education as the social dimension in which the highest level of discriminatory treatment is found in New Zealand. This finding echoes Peace and Kell (2001), who 15 years previously declared discrimination as the “third most highly ranked housing difficulty,” naming it as “ongoing, pervasive,” and “serious” (p. 116). Bécares and Atatoa-Carr describe housing discrimination as being “particularly severe,” with the Māori, Pasifika, and Asian women in their study “more than twice as likely” to experience depression during pregnancy than those who did not report “unfair treatment in the housing sector during the past year” (2016, p. 6). Amongst this cohort, racial discrimination in housing within the last 12 months makes prenatal perceived stress 2.3 times more likely, prenatal depression 2.1 times more likely, and postnatal depression no more likely (Bécares & Atatoa-Carr, 2016). The impacts of racism affect not only mothers but also children born to and raised by stressed mothers directly via cortisol and indirectly via observing and experiencing their mother’s distress (Thayer & Kuzawa, 2015).

Bécares and Atatoa-Carr (2016) echo US researchers when highlighting the need for affordable and high-quality housing to address these issues. A Boston study found improvements in parents' and children's physical and mental health over a six-month period when their housing needs were met (Bovell-Ammon et al., 2020). Physicians in the US have demanded "the right to prescribe housing ... as a cost-saving humane investment in children's brain development" (Padgett, 2020, p. 199). US healthcare workers are defining housing as medical care, with suggestions to embed legal representatives into medical centres to combat the housing inadequacies that lead to poor mental and physical health (Hanssmann et al., 2022; Suglia et al., 2015).

Housing entwines economic factors, mental health, and racial realities. Rising rent costs, fear of eviction, and lack of control over when or if housing repairs will be made can lead to heightened levels of stress and depression (Çaliyurt, 2022; Suglia et al., 2015). Racial discrimination in New Zealand's housing market has "severe direct consequences" for MMH and can affect "children's development" (Bécares & Atatoa-Carr, 2016, p. 9). Even when families secure rental homes, they will experience poorer mental health than homeowners (Mason et al., 2013).

Housing status is so integral to wellbeing that Suglia et al. (2015) suggest healthcare providers ask if patients rent or own on mental health screens. Adcock et al. (2021) emphasise the devastating impacts of private rental insecurity on whānau health but also the positive outcomes for young Māori mothers when their housing needs are met with a balance of autonomy and relational connectedness.

DISCUSSION

There is an inseparable relationship between MMH and housing. Stable and suitable housing significantly enhances the likelihood of mothers and children thriving. Conversely, homelessness, unstable or substandard housing, and housing discrimination impose severe mental and physical health burdens that leave intergenerational impacts on wellbeing. In the most tragic circumstances, the mental health consequences of housing problems can raise suicide risk.

These issues must be understood within the socio-political context of New Zealand, where the housing market is described as "one of the world's most troubled" and our homes as among the least affordable globally (Frost, 2023, para. 3). Addressing MMH and housing, particularly for wāhine Māori, requires confronting the racial dynamics embedded in this "troubled" market. Effective solutions should draw on insights from domestic government and organisational research, which emphasise the vital connections between housing, MMH, and Indigenous sovereignty.

Architectural designer Kake (2019) asserts that the ongoing alienation of Māori from their land is a violation of Te Tiriti o Waitangi. Health outcome inequality is another recognised breach (Came et al., 2020; Paine et al., 2013; Pitama et al., 2014; Wilson et al., 2020). This article lies at the intersection of these issues, arguing that home and health inequalities represent a compounded breach that should be addressed collectively. The *Mana Wāhine Kaupapa Enquiry* (WAI2700, Waitangi Tribunal) is currently investigating "the denial of the inherent mana and iho of wāhine Māori and the systemic discrimination, deprivation, and inequities experienced as a result" (para. 3). The investigation has identified four pou to frame the inquiry: rangatiratanga, whenua, whakapapa/whānau, and whai rawa. No or poor-quality housing undermines all four.

The Helen Clark Foundation (2022) reports suicide as the primary cause of death for New Zealand's pregnant and new mothers. The Productivity Commission's (2022) *Maternal Mental Health Report* estimates that up to a fifth of mothers in New Zealand experience mental health issues, with Māori women "3.35 times more likely to die by suicide" (p. 3). If left unattended, maternal unwellness can have lifelong, intergenerational adverse effects on children (Ministry of Health, 2021; University of Auckland, 2021). Concurrently, New Zealand grapples with a surge in housing troubles that disproportionately affect Māori (StatsNZ, 2021).

The Ministry of Health's (2021) investigation into MMH services mentions "housing difficulties" such as "quality and insecurity" as part of the web of whānau needs that drive the mental health status of perinatal women (p. 15). Māori mothers have described experiencing heightened stress and provocation of past trauma after childbirth, discomfort in mainstream healthcare settings, and reluctance to seek help, often attributing their stress to inadequate housing (Innovation Unit, 2019).

Even if Māori mothers begin seeking care, their needs may not be met by the current system. Only a minority of New Zealand's district health boards offer kaupapa Māori services focused on MMH (Ministry of Health, 2021). Of the 11,000 women who will experience perinatal depression and anxiety each year, 75 to 95 percent of them, depending on location, will have symptoms deemed not serious enough to get support through the healthcare system (Productivity Commission, 2022).

New Zealand's governing and consulting bodies are aware of these health and housing disparities. The New Zealand College of Public Health Medicine (2018) issued a dire housing policy statement that echoes off-shore advocates. Soon after, healthy homes standards were legally codified, and currently, in 2025, all private rental homes must meet minimum heating, ventilation, and drainage requirements to be legally rentable (Ministry of Business, n.d.). Te Whatu Ora's (2023b) Healthy Homes Initiatives (HHIs) led to a nearly 20 percent reduction in housing-related hospitalisations in their trialled areas, including a focus on pregnant women and families on low incomes with tamariki under five.

Unfortunately, these incremental advances do little to remedy the broader housing problems that plague the country. HHIs apply solely to those with homes to make healthy. Often, those houses are not owned by tāngata whaiora, and it is the home owners who ultimately benefit from upgrades. The ideal scenario would be one of widespread home ownership where housing infrastructure is designed to promote physical and mental wellness. Race must be a consideration to close wellbeing gaps, for this crisis disproportionately impacts Māori.

When compared to New Zealand Europeans, Māori are 1.7 times more likely to experience housing instability, 1.4 times more likely to rate their housing as unaffordable, and twice as likely to live in damp housing (StatsNZ, 2021). Even when accounting for the youthfulness of the Indigenous population, Māori home ownership rates fall below those of New Zealand Europeans, with tamariki exceedingly more unlikely to live in a home owned by their parents (StatsNZ, 2021).

A 2023 investigation by *The Listener* further demonstrates that Māori mothers and children are incommensurately impacted by New Zealand's unhealthy homes (Macfie, 2023b). It tells the story of Rarangi and her toddler Te Awhenga, who will have lifelong illnesses arising from the poor quality of their Kāinga Ora house. Even if Te Awhenga is provided a healthy home now, these illnesses may hinder her educational, physical, and psychological growth.

While these realities have been systemically, and perhaps wilfully, disregarded, our community holds the power to galvanise collective awareness and action toward effecting meaningful change. As we navigate solutions, it is paramount to centre the voices and experiences of Māori mothers. This will necessarily include acknowledging and addressing the structural racism and discrimination they face.

The insights above and recommendations below should be woven into the fabric of our advocacy and policymaking under the *te whare tangata* banner, signifying the womb as the foundation of all human life. While figuratively beautiful, the phrase is literally significant. The health of the *māmā* sets the foundation for the health of the *pēpi*, and the health of the *whare* helps lay a foundation for the ability of the *māmā*, *matua*, and *whānau* to protect and nourish *pēpi* and future generations.

RECOMMENDATIONS

We here offer a preliminary outline for a deliberate, actionable, New Zealand-specific “Housing is Healthcare” framework (Lozier, 2019).

1. *Health facilities become sites of MMH/housing crisis response.* Doctors should have the ability to prescribe housing as a “form of ‘preventative neuroscience’” for children (Padgett, 2020, p. 199). “Housing Prescriptions” might include not only direct placement into housing but also assistance for families/whānau navigating the private rental market and accessing legal support to address housing violations without fear of eviction (Bovell-Ammon et al., 2020; Hanssmann et al., 2022; Suglia et al., 2015). This integrative approach aligns with Māori-centred healthcare models that address relational, cultural, and community-specific needs (Wilson et al., 2021). Te Whatu Ora’s (2023a) report on MMH in New Zealand’s central region advocates for mental health support “regardless of severity” and emphasises targeted recruitment of Māori and Pasifika staff to ensure culturally responsive care (p. 14). This integrated model underscores the interconnectedness of housing, mental health, and culturally grounded support.
2. *Unhoused pregnant persons and parents with children in their care are offered Emergency Housing Special Needs Grants.* The first 1,000 days of life—from conception to age two—are widely recognised as a critical period for establishing the foundations of a child’s development (Te Whatu Ora, n.d.; University of Auckland, 2019). MSD is currently stating that these grants will not be offered to those who have “contributed to their own homelessness,” a phrase the lead author hears often in her mahi (Housing First Auckland, 2025). No child, whether born or in utero, can contribute to their own homelessness. Therefore, they should not be expected to reside in a car, tent, or makeshift shelter, particularly during winter months. While emergency housing is not a long-term solution, it provides an essential first step toward safe and stable accommodation.
3. *In keeping with Te Tiriti, hapū tāngata whaiora and matua to young tamariki receive distinct consideration via targeted housing plans.* Even before children are born, home environments, or the lack thereof, establish the basis for their later ability to flourish (DeCandia et al., 2022; Padgett, 2020). New Zealand must act on the evidence that attention to housing for Māori today—even and especially those not yet born—will result in greater wellbeing tomorrow.
4. *A decolonisation lens is more rigorously applied to housing as a healthcare issue.* The Crown must act on its adoption of the *United Nations Declaration on the Rights of Indigenous Peoples* (2007), which states the right to housing and health self-determination. There are current moves in that direction that can begin to address Māori MMH, as detailed in our two remaining recommendations.
5. *Housing should be appropriate in terms of space, culture, and a sense or promise of ownership.* Appropriate housing goes beyond living in a house-like structure. There is promise in efforts to develop papakāinga: houses and communities built on ancestral Māori land (Kake, 2019; Macfie, 2023a). Howden-Chapman et al. (2021) urge the Crown to continue working with Māori authorities in urban areas to develop a “supply of affordable, quality dwellings, including papakāinga” (p. 27). Twenty-first century papakāinga are not hypothetical, as Indigenous designers such as Hoskins et al. (2002) and Kake (2019) have offered clear plans for such communities. The title of a *E-Tāngata* article summarises this prospect perfectly: “Build communities, not just houses” (O’Reilly, 2024).
6. *More support from the banking sector.* For 13 years, only Kiwibank provided mortgage loans for papakāinga, but in 2024, BNZ announced it will follow, as should all financial institutions (Kāinga Ora, 2023; Macfie, 2023a; Nine to Noon, 2024). Seventy percent of Māori land is in rural areas with attendant infrastructure concerns; focused development of the remaining 30 percent that is close to urban areas must be prioritised (Howden-Chapman et al., 2021; Macfie, 2023a). Kake (2021) commends the introduction of medium-density residential standards in the high-growth cities of Auckland, Hamilton, Tauranga, Wellington, and Christchurch as a move towards decolonising housing, as they take into account the multigenerational needs of Māori and Pasifika households. Adequate financial resources are crucial to ensure these initiatives can be effectively implemented.

Limitations

A limitation of this study is its reliance on secondary, predominantly quantitative, research. Further qualitative research that engages directly with wāhine Māori (for instance, Adcock, 2021) across diverse housing environments could provide critical insights to inform housing development strategies. Narratives, alongside statistical data, are essential to understanding the lived experiences behind the numbers. Wāhine Māori, as a maternal demographic, face systemic challenges, including institutional racism and bureaucratic barriers, which have deep historical roots in the dispossession of land and home. However, their narratives also reflect remarkable resilience and strength (Roestenburg, 2023). Their efforts to uphold te whare tangata and advocate for the wellbeing of tamariki and whānau exemplify this resilience. Centring their voices and experiences is imperative to advancing meaningful and culturally responsive solutions in housing policy and development.

Implications for further research

The limitations above highlight directions for further research. Future studies could look at experiences in different housing contexts (such as single-family versus complexes) to inform tailored solutions for social housing. Additionally, research that documents and evaluates promising programmes designed to assist hapū wāhine across the motu, for there are many, could offer actionable insights. There is also a critical need for studies that address the practical implementation of the “Housing is Healthcare” approach. Research could explore the funding, resource distribution, and community engagement necessary to make such an approach viable. Investigating these “how” questions could bridge the gap between conceptual frameworks and real-world solutions.

CONCLUSION

This article examines the impact of housing instability on Māori MMH. Addressing this issue requires housing solutions that are evidence-based, achievable, and that honour the deep connections between motherhood, land, home, and child wellbeing. Our review of the research sought to identify the most effective societal lever to reduce Māori perinatal distress and suicide. We believe we have identified that lever: the “Housing as Healthcare” framework. The pressing question now is how to embed that framework within New Zealand’s social and healthcare services. Until Aotearoa treats housing as a human right—not a privilege to be bought and sold—the wellbeing of all New Zealanders will remain compromised and our obligations under Te Tiriti unmet.

Kim Taylor is a former Humanities lecturer and community organiser. She now works in the social service sector of Aotearoa as Kaiārahi/Team lead at The Loft Community Wellbeing Services in Ōtautahi Christchurch.

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