

# **Matariki**

A Monograph Prepared by Te Mata o Te Tau  
The Academy for Māori Research and Scholarship

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Te Mata o Te Tau; The Academy for Māori Research and Scholarship, was formally established by Massey University in 2003. The Academy sits within the Office of the Deputy Vice-Chancellor (Māori) and extends across Massey University's three main campuses.

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## About Te Mata o Te Tau

*Matariki atua, ka eke mai i te rangi e roa, e whangai iho ki te mata o te tau, e roa e, hei tuku i ngā wānanga i ngā kai ki te ao mārama.*

Te Mata o Te Tau; The Academy for Māori Research and Scholarship was launched in 2003 to provide a forum for fostering Māori academic advancement and creating new knowledge. The Academy is interdisciplinary and intersectoral and unites Māori scholars from several disciplines, departments, and centres of research. It has strong links with other academic and research bodies in Massey University, in New Zealand, and with indigenous scholars overseas.

The **broad aims** of the Academy are;

- the advancement of Māori scholarship
- the provision of a forum for Māori scholars to collaborate across academic disciplines and subject areas
- the promotion of high quality research that will contribute to new knowledge
- and positive Māori development
- the provision of leadership for Māori academics at Massey University.

The name of the Academy is linked to Matariki, the star constellation known also known as Pleiades, and symbolises the promise of a fruitful year, and the advancement of knowledge.

## About this Monograph

Consistent with the desire to advance scholarship and promote Māori research excellence, this monograph is designed as a forum for Māori researchers and academics and provides a means through which ideas on a range of issues, connected to Māori development, can be considered.

This monograph provides another avenue for publication and which complements already existing mechanisms.

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# INDIGENOUS RESILIENCE

*From disease and disadvantage to  
the realisation of potential*

*Mason Durie*

This paper was first presented at the Pacific Region Indigenous Doctors Congress (PRIDOC) in December 2006 at Rotorua.

## **PUKAWA 1856**

The Pacific Region Indigenous Doctors Congress (PRIDOC) 2006 occurs 150 years after an important historic event in New Zealand. In November 1856, 1600 tribal leaders gathered at Pukawa, Lake Taupo, to discuss strategies that would enable them to better cope with mounting risks associated with migration from England, Scotland, Australia and other parts of the globe. Loss of autonomy, alienation of resources, especially land, and a lack of voice in governance were major concerns for the participants.<sup>1</sup> Hosted by Iwikau te Heuheu, a chief from Ngati Tuwharetoa, the ostensible purpose of the meeting was to select a Māori king who could provide a focus for united action and a unified approach to slow down the sale of tribal lands. Even though it could impose excessive demands on tribes and was not entirely compatible with the customary style of leadership based around tribal structures, tribal authority, and tribal independence,<sup>2</sup> the meeting agreed that the selection of a

king was one step towards refocusing Māori energies to meet changing circumstances.<sup>3</sup> Eventually, although he was not at Pukawa, Potatau te Wherowhero became the unanimous choice for King and finally agreed to be anointed in 1858.<sup>4</sup>

There are two reasons why the Pukawa meeting has relevance for indigenous doctors from the Pacific region. First the participants at Pukawa recognised that the imposition of new political, economic and social agendas demanded an innovative response to ensure survival. PRIDOC is also concerned with new solutions to deal with contemporary situations. Second, however, although survival was indeed a real threat in 1856, mere survival was not regarded as a sufficient endpoint; the more significant goal was to establish an environment where the indigenous people of Aotearoa could flourish and prosper, with a sense of equality and a capacity for self management. The PRIDOC focus on excellence captures some of those same aspirations. Pukawa provided a platform for nurturing resilience.

## **CHARACTERISTICS OF RESILIENCE**

There is now world-wide concern for the health of indigenous peoples.<sup>5</sup> At the fifth session of the UN Permanent Forum on Indigenous Issues in 2006 a programme of action dedicated to the worlds Indigenous peoples was launched. Indigenous people make up six percent of the world's population accounting for some 370 million people spread across 70 countries. Most have high mortality rates for specific disease and injury with substantially lower life expectancy than non-indigenous peoples.<sup>6</sup>

While efforts to redress the problems have largely focussed on managing disease and injury, other approaches have explored reasons why some groups exposed to similar stresses and risks have remained well and even flourished. Superimposed on



adversity and historic marginalisation, indigenous resilience is a reflection of an innate determination by indigenous peoples to succeed. Despite threats of genocide and ethnocide, indigenous peoples in the Pacific have endured and prospered to the extent that they are now in significantly stronger positions than they were 150 years ago. Resilience is the polar opposite of rigidity. It provides an alternate perspective to the more usual scenarios that emphasise indigenous disadvantage, and allows the indigenous challenge to be reconfigured as a search for success rather than an explanation of failure.

Indigenous success, the precursor to resilience, has several dimensions but essentially encompasses individuals and groups, a capacity for positive engagement, and a level of autonomy. Much of the literature on resilience centres on the potential of individuals to overcome personal trauma and succeed. However, resilience is also about the achievements of collectives: families, whānau, communities, tribes, mobs, and whole populations. Success in that sense is a shared experience which reflects an ability to adapt and a propensity for turning adversity into accomplishment.

Two broad capacities underpin indigenous success: a capacity to engage with indigenous culture, networks and resources, and a capacity to engage with global societies and communities. The duality recognises the two worlds within which indigenous peoples live and the skills needed to negotiate both. Successful engagement with the indigenous world is facilitated by spiritual and cultural competence and acceptance by communities, while engagement with global societies is eased by the acquisition of technical skills, educational qualifications, and a capacity to deal with bias and prejudice.

A third aspect of indigenous success is built around autonomy and self-management. It applies equally to families,

communities and whole indigenous populations. Resilience is less likely if indigenous futures are premised on the aspirations of others. Instead indigenous success requires a capacity for indigenous approaches to governance and management that are compatible with the world views of families, tribes, and indigenous communities while at the same time being attuned to wider societal values and economies. Autonomy does not necessarily mean an independent pathway but seeks opportunities for collaboration and co-operation on the basis of equality and shared goals.

## **THE DETERMINANTS OF INDIGENOUS RESILIENCE**

Resilience is shaped by many forces acting alone or together. They can be grouped into broad determinants: demographic transitions, human capability, cultural affirmation, attitudinal biases, the economy, lifestyle environments, policies of the state, indigenous mobility, and leadership.

### **Demographic Transitions**

In 1856 the Māori population was in a state of decline. Even by 1836 there were reports that the population had been reduced by more than a quarter and by 1906 it was estimated at 45,000 – a reduction of more than 75 percent from 1806. Although extinction was widely predicted, not only did Māori survive, within a century they had become more numerous than at any other time in history. Even though changes to statistical definitions of Maori make it difficult to draw exact comparisons, there is strong evidence of a substantial and sustained increase in the Maori population. In the 2001 census 526,281 New Zealanders identified as Māori with a median age of 21 years.<sup>7</sup>

Further, although accounting for some fourteen percent of the total New Zealand population in 2001, by 2051 the Maori ethnic population will almost double in size to close to a million, or

twenty-two percent of the total New Zealand population. Even more dramatic, by 2051 thirty-three percent of all children in the country will be Maori and the percentage of the population over the age of 65 will steadily rise from three percent (1996) to 13 percent (2051) as life expectancy increases.<sup>8</sup>

While the figures vary from country to country, and stages of development are either accelerated or delayed, many of the demographic trends observed for Māori are common to indigenous peoples in the wider Pacific: fast growing populations, a lower than average median age, and a large cohort of young people. Of the Australian indigenous population for example, 40 percent are below the age of 15 years compared with just 21 percent of the non-Indigenous population.<sup>9</sup> In addition there are early signs of an ageing population; gradually the median age will increase as life expectancy rises.

In addition to the overall growth in indigenous populations, two particular trends have special relevance for resilience: youthfulness and increases in the numbers of older people. Youthfulness can be associated with high levels of risk taking and in that sense represents a threat to good health, but it is also a sign of vitality, potential and a greater likelihood of innovation. And an increase in the proportion of older people not only reflects greater life expectancy but also an increased capacity for the inter-generational transmission of culture, wisdom and leadership.

### **Human Capability**

Insofar as resilience is about overcoming adversity and reconciling tensions within complex and often contradictory societies, much depends on human capabilities to manage new environments and wield together indigenous world views with views derived from science, business, law and environmental management. Two indicators of capability of particular

relevance to PRIDOC are indigenous participation in tertiary education and indigenous representations in the health workforce.

There are signs that on both counts indigenous participation is increasing. For Māori learners for example there have been significant gains. Retention rates for sixteen year olds at secondary school increased from 47 percent (in 1987) to 63 percent in 2003). Between 1983 and 2000 the percentage of Maori students who left school with no qualifications decreased from 62 percent to thirty-five percent, while at the tertiary level, between 1993 and 2004 Maori participation increased by 148 percent. By 2002 Maori had the highest rates of participation in tertiary education of any group aged at twenty-five years and over. Although the significant improvement masked the fact that Maori were still five times more likely to enrol in Government remedial training programmes and three times less likely to enrol at a University,<sup>10</sup> around seven percent of the total university population in 2005 is Maori. But most of the recent tertiary education growth has occurred through accredited tribal learning centres, wānanga, which increased enrolments from 26 000 students in 2001 to 45 500 in 2002.<sup>11</sup>

Similar growth has been seen in the composition of the health workforce. As one way of addressing the disproportionate representation of Māori in most illnesses and injuries, workforce development has become a high priority for improving Māori standards of health. In 2000, Māori made up around 14 percent of the total population but only five percent of the national health workforce.<sup>12</sup> In order to increase the size of the workforce, there have been deliberate efforts to attract Māori into the health professions through affirmative action programmes – or programmes that have similar aims. In 1998 for example the University of Auckland launched *Vision 2020*, a programme designed to significantly increase Māori entry into the medical

school. In 1984 there had been around 5 new Māori medical students each year but by 2004, the number of new Māori entrants had increased to 24.<sup>13</sup> Similar trends have been seen in the qualified medical workforce. From an estimated workforce of around 60 in 1984, there are now over 200 Maori medical practitioners across range of specialties, accounting for three percent of the total active medical workforce. In addition scholarships have been offered from a number of sources as incentives to encourage enrolment in other disciplines such as nursing, social work, clinical psychology and addictions. The number of Māori dentists for example has increased from 4 or 5 in 1984 to 44 in 2005.

Indigenous education in Australia has seen similar developments. There have been significant increases in the number of indigenous Australians enrolled in higher degrees – over 25 percent between 2001 and 2003 – and a discernable shift towards ‘indigenising the curriculum’ has been evident.<sup>14</sup> Further, a best practice framework for the recruitment and retention of indigenous Australians into the medical workforce was launched in 2005 by the Australian Indigenous Doctors Association. *Healthy Futures*, has been endorsed by the Government and accepted by Australian medical schools as a template for action.<sup>15</sup>

An important aspect of human capability building – and especially germane to indigenous resilience – has been the incorporation of indigenous world views into education and training. It is no longer acceptable that education and training should lead to the abandonment of an indigenous identity. As an agent of resilience, capability building requires that professional, technical and interpersonal skills are learned in a way that strengthens identity so that students and trainees can bring indigenous inventiveness to the workplace and ultimately provide services that will be relevant to indigenous peoples.

### **Cultural Affirmation**

A third determinant of indigenous resilience is linked to the ways in which indigenous language and culture are expressed in modern times. Language resilience is evident by the proportion of people who speak an indigenous language and the number of domains where that language can be heard. Where indigenous people are a minority population, and even occasionally where they are a majority such as in Ireland, indigenous language domains are generally limited and there is debate about the appropriateness of applying them to all fields rather than concentrating on a few. But increasingly the boundaries have been pushed out and (for example) Māori language has been woven into radio and television, into education and health promotion, and more recently into popular music including rap. Those innovations are consistent with the view that a resilient language is one that is used in both contemporary and customary contexts.

Indigenous resilience cannot be solely measured by indigenous participation in society since resilience is also about the way in which indigenous philosophies, styles of thinking, conceptualising, and turns of phrase are expressed in schools, at work, and in leisure time. Aligning cultural world views and indigenous knowledge with other knowledge systems and exploring the interface between them has unrealised potential.

‘Living at the interface’ was a theme at the first PRIDOC conference in 2002. A tendency to appreciate indigenous knowledge and culture only because of its historic associations would miss any relevance for today and fail to capture the potential for knowledge expansion. In medical practice there is the opportunity to expand the basis for medicine by creating foundations drawn from the scientific tradition as well as the indigenous traditions. In that process

indigenous doctors are well placed to show leadership and a capacity to work within two systems.<sup>16</sup>

Over the past decade progress in aligning indigenous culture with professional development has occurred in several areas. For example environmental protection, based on cultural perspectives of sacredness and identity has been discussed in relationship to health in Palau<sup>17</sup> and the integral significance of culture to health research has been emphasised in Pacific community based research proposals.<sup>18</sup> Repositioning traditional healing within a social science context has also been seen as an important step to improving health services in Tongan communities and the grouping of healing with conventional health services has been postulated as a useful approach.<sup>19</sup>

### **Attitudinal Bias**

Although the pathways to success are complex with multi-determinants, there is empirical evidence that indigenous achievement (or non-achievement) is very often a product of the attitudes of others – professional bodies, national organisations, state governments, international agencies, non-indigenous members of society, and indigenous peoples themselves. Expectations for indigenous peoples, especially where they are minorities in their own lands, are seldom high or indeed afforded priority and are not infrequently negative and disparaging. Many indigenous communities also have low levels of ambition and do not expect that their own people will be able to rise above adversity and exercise both leadership and control over their future directions. Lack of success becomes a self-fulfilling prophecy.

Reversing entrenched attitudes will be no mean task. But there are encouraging examples where major attitudinal changes have occurred in recent times. The 1984 Hui Taumata led Māori to refocus energies away from state dependency towards self

management, economic self sufficiency and self determination. Expectations of failure, trapped lifestyles and mediocrity are now increasingly balanced with expectations of success, innovative discovery, and collective wellbeing. In Australia the establishment of an Indigenous Higher Education Advisory Council in 2005 has provided for a vehicle for the advancement of indigenous students and academics through improved policies and strategies. The motivation for PRIDOC has similar objectives – the creation of a forum where indigenous doctors from the Pacific can anticipate success on dual fronts: success in professional and technical spheres and success in realising indigenous goals. Moreover a standard of excellence has been promoted.

### **The Economy**

Resilience is more likely where economic circumstances are favourable and the indigenous resource base is strong. Many indigenous peoples have experienced serious erosion of customary resources, especially land. Currently for example Māori own around five percent of the total New Zealand land mass much of which is scarcely arable. Over a century and a half, and by one means or another, some 25 415 029 hectares were lost. The massive alienation of a once substantial estate had been the product of imposed reformation of land tenure, a shift to a cash economy, large and small-scale pastoral farming, mining, new perspectives on the value of land, urban development, tourism, conservation measures in the name of national interest, and an element of avariciousness. Moreover, alienation of Māori land did not apply only to surface rights but also came to include sub-surface rights to minerals, gas and geothermal energy.

Natural resources, including forests and fish as well as land, are important contributors to indigenous resilience. Partial restitution of resources through the settlement of grievances has improved the economic circumstances of some tribes and as



Treaty settlements and fisheries investments mature, the Māori economy shows signs of gaining strength.<sup>20</sup> But increasingly Māori are looking to other resources to provide economic security and resilience is being linked to exploration of the knowledge society and participation in the knowledge economy. Because the population is expanding at a faster rate than the physical resource base, that trend is likely to continue, not only for Maori but for Pacific peoples whose island based resources are similarly unable to provide sustainable economic growth into the future.

### **Lifestyle Environments**

A common characteristic of indigenous peoples is a capacity to relate to the natural environment. All indigenous people perfected the art of adaptation in order to live in harmony with nature. In Aotearoa for instance the laws of tapu constituted a type of public health code which minimised risk and promoted an ethos of sustainability. But synergy with the natural environment has become less relevant in urban environments and increasingly the challenge has been to adjust to new, man-made environments and their associated non-communicable diseases.<sup>21</sup> There are many examples where adjustments have been successful though not necessarily before considerable damage was inflicted. Overcoming endemic tuberculosis and in recent times reducing the incidence of meningococcal meningitis are markers of successful adaptive processes.

However, other environments remain to be harmonised. The rate at which carbon fossil fuels are burned has created a global warming problem with climatic change, threats of a greenhouse environment, and the emergence of new sets of health problems on a scale that has not been previously known.<sup>22</sup> There are also new social and cultural environments that predispose to mental disorders such as depression, alcohol and drug misuse,<sup>23</sup> and increasingly urban populations are faced with consumer

environments that foster, among other things, type II diabetes. Speaking at the International Diabetes Federation's, 'Diabetes in Indigenous People' Forum in Melbourne in November 2006 Professor Zimmet from the International Diabetes Institute showed that diabetes had become a major and deadly threat to the continued existence of some indigenous communities throughout the world as a result of western lifestyles and diet. Media reports in New Zealand concluded that unchecked, the diabetes problem could lead to Maori becoming extinct.

Predictions of extinction are not new to Māori. By 1874 the *New Zealand Herald* was convinced the end was nigh: 'That the native race is dying out in New Zealand there is, of course, no doubt...The fact cannot be disguised that the natives are gradually passing away; and even if no cause should arise to accelerate their decrease, the rate at which they are now disappearing points to their extinction in an exceedingly brief period.'<sup>24</sup> But by failing to take into account Maori resilience and adaptability reports of extinction have been remarkably inaccurate. While recognising the seriousness of diabetes, and its increasing prevalence, the facts point to a resilient people with a capacity to adapt and succeed. The rate of adaptation and the expression of resilience in response to the threats of diabetes and other lifestyle disorders, will not only depend on the quality of information, access to early intervention, and the strength of indigenous leadership but also on the development of a code of living that is comparable to codes that were fashioned when Māori learned to live harmoniously with the natural environment. It is perhaps a task for PRIDOC.

### **Policies of the State**

Key to preparing for the future is a need for policies that will facilitate resilience and the realisation of indigenous potential. Policies that recognise indigenous peoples as risks will do little to actively promote strengths or encourage innovation.

An important policy issue revolves around the ways in which states value indigeneity and two issues are often allowed to cloud the issue. First, addressing cultural diversity is not the same as recognising indigeneity or agreeing about the place of indigenous peoples within the modern state. Equal rights for all cultures endorses cultural respect but does not address the issue of indigeneity which is only partly about culture. Second, the position of indigenous peoples within a state is not solely about socio-economic disadvantage, or health risks. Those considerations are germane to all people. Indigeneity is essentially about a set of rights and responsibilities that embrace economic, social, environmental and cultural dimensions, and the nature of the relationship to the state.

The distinctions between a celebration of culture and indigeneity are clear in the Draft Declaration of the Rights of Indigenous Peoples. After twenty years the Draft Declaration was widely supported by indigenous peoples from around the world, had been adopted by the UN Human Rights Council in June 2006 and recommended for adoption by the General Assembly. But a “no action” motion was advanced in the Third Committee of the UN General Assembly at the November 2006 session. African states, as well as Samoa, Micronesia, Kiribati, New Zealand, Australia, Canada and the United States of America were opposed to some aspects of the Draft and led the move to stall it. Other states including Tonga and Vanuatu abstained. In the event a global opportunity to facilitate indigenous resilience was put on hold for further consideration before the end of the 61st session of the UN General Assembly (September 2007).

Lack of state support for indigenous causes is not new. New Zealand has been through a two decade process of settling claims between Māori and the state brought about by disregard for indigenous property and cultural rights. And some states have found it difficult to distinguish between indigenous rights and

interests on the one hand and ethnic interests on the other. As societies become increasingly multi-cultural, the recognition of ethnic diversity will become more important and the celebration of their various cultures will add to the wealth of each nation. But important as ethnic and cultural rights are, indigenous rights constitute another dimension and require responses from states that are not based solely on cultural difference or ethnic diversity.

### **Indigenous Mobility**

A primary characteristic of indigenous peoples has been a longstanding relationship with land, forests, waterways, oceans and the air.<sup>25</sup> That characteristic is expressed in language, song, dance, and gatherings where tribal customs and aspirations can be shared. Increasingly, however, indigenous peoples have migrated away from homelands, either through a process of urbanisation or migration to other countries. Maori, Australian Aborigines and Torres Strait Islanders have moved in large numbers from rural areas to reside in towns and cities. Though still linked to traditional lands, and often retaining strong interests in them, their lives are largely shaped by metropolitan environments. Pacific Peoples have also moved to new environments. When island economies have been unable to sustain expanded populations, families have migrated to neighbouring countries such as New Zealand and Australia, where work and education can be obtained.

The diaspora – whether urban or transnational – has sometimes been seen as a weakening of indigenous identity and potential. However, over time it has become apparent that many tribes in New Zealand, and many Pacific nations, have remained resilient not in spite of the diaspora but because of the diaspora. While those who leave home do not necessarily retain the same idiom or the same values as those who remain behind, a commitment to their own people may be no less and re-connections will be

valued. The capacity to contribute to indigenous resilience may be increased by new skills, expanded networks, different organisational arrangements, and fresh visions acquired in distant environments.

### **LEADERSHIP - INDIGENOUS DOCTORS AND INDIGENOUS RESILIENCE**

By virtue of their training and standing in the community, indigenous doctors can contribute to the promotion of resilience in two ways. Most obviously, improving health status will increase levels of resilience; but in addition doctors are well placed to participate in the conversion of environments that diminish resilience into environments that can enhance resilience.

Apart from public health physicians who have professional interests in whole populations, most doctors are concerned with the treatment of injury and disease for individual patients. In that respect the possible contribution to indigenous resilience is high, at least for individuals. But the promotion of resilience is likely to be even greater if the diagnostic and treatment process can address human potential as well as human pathology. While time spent with patients is valuable and inevitably never long enough, and notwithstanding the energies and costs required to establish a diagnosis and devise a treatment plan, should a medical examination also attempt to identify pathways that will lead to positive lifestyles and success in terms that are relevant to indigenous resilience? Is there a case for indigenous doctors to take a lead in the development of schedules and instruments that are capable of unravelling the foundations of potential alongside the foundations of pathology?

Moreover, when considering resilience from the perspective of indigenous peoples as whole populations, there is another role

for doctors, not necessarily as healers but as part of an indigenous leadership network. Leadership remains fundamentally important to indigenous development in modern times. Indigenous leaders need to be expert in navigating modern environments while remaining in touch with indigenous realities, indigenous aspirations and indigenous culture. As leaders, health professionals need to be able to establish positive relationships with a variety of institutions, communities, sectors, tribes, and systems of knowledge. Independently and collectively their influence with governments, professional bodies and their own people could be instrumental in converting hazardous environments to environments that are conducive to the emergence of resilience and potential.

While elders exercise leadership roles on the basis of a broad understanding of the overall aspirations of their people, indigenous doctors have professional and technical skills that are the product of lengthy training. But they will also need to be comfortable working at the interface between indigenous worlds and worlds dominated by science, law and economic theory and will need to be equally comfortable working with indigenous colleagues from other disciplines and callings. Leadership embraces diverse skills and knowledge sets and will be a major contributor to resilience. The establishment of academies for Indigenous Leadership could serve a useful purpose. Leaders in a range of endeavours such as education, commerce, the law and environmental management might join with leaders in health to learn skills relevant to indigenous futures, and to deliberately foster a climate of resilience.

## **SUMMARY**

Exploring indigenous resilience is an alternative way of understanding indigenous health. A number of determinants impact on resilience including demographic transitions, human capability, cultural affirmation, attitudinal biases, the economy, lifestyle environments, policies of the state, indigenous mobility, and indigenous leadership. To a large extent those determinants, together and individually, mediate between successful outcomes and outcomes where disease, disadvantage and deficit prevail.

Success is a precursor of resilience and has at least three core characteristics. Success refers to individuals, groups, tribes and the indigenous population as a whole. A successful person whose success is not mirrored in the success of others does not necessarily contribute to indigenous success. Success is also reflected in the quality and quantity of indigenous engagements with wider societies as well as with indigenous societies, and is further characterised by a high degree of autonomy and a capacity for self management, self governance, and collaboration.

Where there is success there is likely to be sufficient resilience to overcome adversity and disadvantage and to prepare the way for other individuals and groups to follow similar successful pathways. The task is to reduce adversity where it can be reduced and to build resilience so that any consequences of adversity do not outweigh the capacity of indigenous peoples to thrive and prosper.

## **EPILOGUE**

If there were a central lesson from Pukawa in 1856 it was that resilience must be nurtured and actively led. In November 2006 more than 5000 Māori gathered at Pukawa to open a new tribal

house and to remember the gathering that had taken place 150 years earlier. The event was led by descendants of Te Heu Heu and Potatau te Wherowhero. Not only had the lineages survived but there was evidence that they had prospered, grown in size and attracted wider support. Tumu Te Heuheu was the host and Tuheitia Pahi, who had been anointed the 7th Māori King only three months earlier, was the guest of honour. Together they, and their people, epitomised the spirit of Maori resilience.

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# THE DEVELOPMENT OF CULTURAL STANDARDS IN EDUCATION

*What are the Issues?*

*Huia Jahnke*

This paper was presented at the Te Mata o Te Tau “Hokowhitu” Lecture Series on August 23, 2006, in Palmerston North.

## INTRODUCTION

If there is a single motivating factor for the establishment of tribal education strategies it is an overwhelming desire and ambition by tribes to advance tribal aspirations. These include the development and enhancement of tribal capacity and identity; the revitalisation and maintenance of tribal reo me ona tikanga; and ensuring positive outcomes that lead to successful educational achievement levels of Māori children in their rohe.

The perceived efficacy of kōhanga reo, kura kaupapa, wharekura and wānanga on the lives and wellbeing of Māori children and their whānau are held as the benchmark against which tribal aspirations are determined. In the past Māori have had little say in decisions that have helped shape schooling in Aotearoa, and overtime this system has not worked for Māori children. Some tribes have moved to develop iwi specific cultural standards in

education as a further strategy to outline and make clear to the education community, policy makers and politicians alike, what tribal expectations are for students, the whānau, the community, the teachers, curriculum and the operation of schools. There are at least three assumptions underpinning the development of iwi-specific cultural standards that reflect tribal expectations.

First is a commitment by tribes to ensure access to and the transmission of tribal knowledge in relevant contexts and institutions. This is often referred to as the 'iwitanga' factor (Kahungunutanga, Tuhoetanga) which includes the revitalisation of te reo me ona tikanga, especially the maintenance and active usage of distinctive tribal dialects.

Second is an assumption that as tangata whenua tribes have a role in facilitating stakeholder relationships with the state that contribute to mutually beneficial outcomes in relation to access and participation in education, and increasing educational achievement and retention rates. There is also concurrence across tribes of a responsibility to uphold the interests of all children and their whānau who reside within their rohe besides their own tribal beneficiaries.

Third, is the capacity at the whānau, hapū or iwi level, to offer schools relevant frameworks to engage with whānau, hapū and the wider Māori communities. This can include access to cultural resources from which schools might otherwise be excluded. This is an important consideration where aspects of tribal history are regarded as priorities by tribes for inclusion in school programmes.

The process of developing iwi specific cultural standards in education is a complex one. On the one hand tribes are aware of the challenges they face on a number of levels and especially gaining the commitment of schools and the education community

to advance tribal aspirations. Māori have a long history and experience of schooling in a colonial and neo-colonial era and of dealing with and responding to the hegemonic consequences of the will of the State. To some extent this has resulted in an ability, and political *savoir-faire* at reading, interpreting and dealing with the Eurocentric mindsets of politicians, policy makers and institutional bureaucrats. As Michael King observed thirty years ago, “Māori opinion is now sufficiently articulate and mobilised to impede public policies when they do not invite such consideration”.<sup>1</sup>

On the other hand there is also the challenge of accounting for diverse tribal interests, points of view and personal agendas that are not always in unison and not letting these distract from the pursuit of the bigger goal by maintaining a unity of purpose and clear processes.

Inevitably, tribal expectations in relation to cultural standards raise questions regarding definitions of culture, who defines such definitions, what constitutes standards, how they will be measured, by whom and on what basis? Some tribes have elected to substitute the term cultural standards and to adopt Māori terms that describe more precisely what they understand cultural standards to mean.<sup>2</sup> The notion of standards associated with state schooling is highly contested generally and is particularly contentious for Māori. This is because standards are inextricably linked with measurements. Standardised tests and public examinations are among the chief sorting mechanisms for evaluation and assessment procedures in schools that are usually set against highly selected, often taken for granted sets of ‘acceptable norms.’ The outcomes of such procedures have tended to pathologise Māori educational achievement thereby raising questions about whose interests have really been served. Evaluations and assessments per se may not be the problem, but

what counts as ‘acceptable norms’ and faulty or inappropriate measures may well be.

Invariably standards are about knowledge which bring to bear those critical questions regarding what knowledge counts, how knowledge should be organised (the curriculum) and/or packaged (as textbooks) for transmission? Transmission is concerned with pedagogy, with learning, with the curriculum and its construction. Which raises further questions regarding how learning will be facilitated and by whom? What criteria are necessary in pre-service selection and training of teachers? What are the implications of this for Colleges of Education and other pre-service providers? What do teachers need to know in order to ensure successful outcomes for Māori children? Schools serve to act as key agents of cultural and ideological hegemony and of selective traditions. The cultural capital that is enshrined in the schools habitus operates to reward and fail students in accordance with the cultural capital they bring.<sup>3</sup>

Most Māori children in Aotearoa are located in schools where there is often a cultural discontinuity and dissonance between home and school, between the lived realities of whānau and what Bourdieu describes as the habitus of the school.<sup>4</sup> These schools are generally described as mainstream. The term mainstream is a euphemism or code word for schools that are oriented within a western /Euro-centric tradition. When we think of mainstream schools we think of schools that are controlled by those who have political, economic and cultural power and which position western values, knowledge, culture and the English language as the central focus of the total school habitus. Incorporation of aspects of Māori language and culture, the ‘taha Māori’ factor, are either ‘add-on’s’ to the core curriculum or can be found superficially expressed as Māori/English signage for school buildings and offices.<sup>5</sup>

For many Māori children mainstream schools are sites of alienation reinforced by the disjunction between home and a Eurocentric school milieu. In this context what counts as school knowledge, the way school knowledge is organised, resourced, taught and evaluated, the underlying codes that structure such knowledge, access to and legitimisation of school knowledge is determined by the dominant culture.<sup>6</sup> Underpinning these epistemological concerns, knowledge transmission and what constitutes the curriculum, are values. What values count and how values are understood, practiced and legitimised are important considerations when we think about what the purpose of education ought to be.

In the context of Aotearoa New Zealand, an overwhelming premise among Māori generally is that Māori cultural values, customs and worldview are essential elements that distinguish the people, this land and our identity as a nation from any other place on earth. They are the defining characteristics and values that make us unique. There are indications that the wider New Zealand public might think so too. When I began preparing this presentation I intended to reference several examples to demonstrate my point.<sup>7</sup> But these have been overshadowed by the extraordinary events that have unfolded as a consequence of the passing of Te Arikini Dame Te Atairangikaahu. This marks a defining moment in the history of this nation for many reasons most notably the loss of someone who demonstrated the ultimate measure of great leadership; the ability to lead the people of Tainui and the Kingitanga by following them with wisdom, dignity and humility.

Over the six day period of the tangi the media coverage exposed many glaring gaps in the understanding between Māori and Pākehā. It seems inconceivable that only a small minority of Pākehā could share Māoridom's sense of loss. The lack of

knowledge about Māori history among the general New Zealand public was palpable.

The live television broadcast of the final day, demonstrated significant changes in thinking by mainstream television powerbrokers around cultural standards and the media. In particular, recognising that the locus of knowledge and ability to document and explain Māori life, customs, histories and traditions and do so with integrity lay with Māori members of the media. The result was a production that in my view was an outstanding and sensitive coverage of a significant moment in history. Māori television's decision to broadcast live may well have been the leverage that held the Nation's premier television station to account and trust the expertise and experience of a substantial team of Māori journalists to deliver. It was obvious during the live broadcast that at every bend Māori controlled the flow of information, who had access, who were appropriate to anchor the programme including locals with insider knowledge. Māori determined the scope regarding what was applicable and culturally appropriate to be filmed for public consumption and what was not. These were recorded with the eyes and sensibilities that only an intimate knowledge of the Māori world could conceive. In matters of cultural standards, there is a fine line between journalistic voyeurism on the one hand, and sharing publicly what is an otherwise profoundly personal time while recording for posterity history in the making. For the general public the result was a unique and rare insight into the values and customs, associated with the most significant of institutions that have sustained Māori culture since time immemorial.

Overall, the cultural divide exposed by the media at this time and from other events in recent years, suggests that in the main the New Zealand public are still relatively ignorant of Māori culture, customs, history, knowledge, values and institutions. And in this we are a nation still coming of age.



Yet State recognition of the importance of Māori custom and values is reflected in their inclusion in New Zealand law, particularly since 1984 when bicultural / Treaty of Waitangi jurisprudence emerged. Influenced by the work of the Waitangi Tribunal,<sup>8</sup> the Māori Language Act 1987 accepted the Māori language to be a 'taonga' and subsequently Te Reo Māori was declared an official language of New Zealand. The State Enterprises Act 1988 recognised the importance of returning alienated waahi tapu to the appropriate tribe in lieu of transferring title to a state-owned enterprise. The Resource Management Act 1991 recognised the significance of Māori custom, values and attitudes associated with ancestral lands, natural resources and other taonga as a matter of national importance.<sup>9</sup>

There are signs that the call to eliminate race-based policies by stripping away all references to the principles of the Treaty of Waitangi from legislation, social sector contracts and policies, in favour of a needs based 'one law for all' approach is evident in the education sector. Redirecting funds from programmes that specifically target and benefit Māori students (such as access to tertiary education) to support teachers of Māori students in mainstream secondary schools<sup>10</sup> is an example. Current figures show 7% of secondary teachers are Māori so the redistribution of benefits from one group to another simply maintains the status quo unless the flow-on effect of supporting teachers' results in positive educational outcomes for Māori students.

The notion of race-based policies is a myth, a misleading categorisation aimed at political point-scoring. It is misleading because the term obscures the genuine concerns of Māori, Pakeha and other non-Māori experts in education, health and social policy based on equity and justice. The problem with labelling equity-based programmes and policies as race based is

that it confuses race with ethnicity rather than seeing such programmes as a systematic approach to presenting Māori as the subject. It attempts to deflect attention away from the facts and ignore the burgeoning body of empirical evidence which highlights the link between ethnicity on the one hand and poor health and education outcomes including access and participation, on the other.<sup>11</sup>

The newly released draft curriculum is a case in point where references to the Treaty of Waitangi are absent and biculturalism replaced by an emphasis on diversity. In the United States, the notion of diversity has been a favourite of corporate CEO's, education administrators and politicians. The preoccupation among these groups with diversity is a proclivity to consider it as cultural when in fact diversity is a matter of identities.<sup>12</sup> Accounting for diversity suggests measures to preserve the authentic character of subsidiary identities of a community that, in the absence of references to the Treaty, implicitly includes Māori thereby undermining the status of Māori as tangata whenua. Diversity of identities as subsidiaries can only be understood by their relationship to the majority.

If the principle of diversity is simply spectatorial, that is to support what African philosopher Kwame Appiah suggests as “the vista of diversity...the spectacle of the emperor's zoo so to speak” then it is essentially there for our appreciation or as token gestures.<sup>13</sup> Programmatic promotions of diversity as outlined in the draft curriculum, while upholding differences may well entail imposing uniformity. In the real world, entrenchment of uniformities happens through the mobilization of state resources and regulative mechanisms in line with government economic and social objectives. As Kwame Appiah maintains “...many value diversity not because it is a [*public or cultural*]<sup>14</sup> ‘good’ but because we take it to be a correlative of liberty and non-domination”.<sup>15</sup> If this is so, then the curriculum simply masks

the status quo keepers who want to maintain a Eurocentric framework "...because they have no faith in cultural pluralism without hierarchy".<sup>16</sup>

Those who defend the status quo have often argued a position of territoriality, that there is no time in the curriculum or school year for including Māori language, culture and history as core components for example. The assumption is that there is little cultural information to speak about or is worthwhile knowing. In so far as the draft curriculum is concerned, it is almost an oxymoron to think of diversity in a document that promotes the individual in a society where liberal values such as the autonomy of the individual are paramount.<sup>17</sup>

### **DIFFERENT APPROACHES**

Iwi education plans and strategies are not new. In 1975, Ngāti Raukawa developed and implemented an iwi development plan Whakatipuranga Rua Mano as an intervention measure aimed at ameliorating the critical decline in the number of Māori language speakers in the iwi. A focus on tertiary education and the development of Te Wānanga o Raukawa emerged as part of the overall tribal strategy.<sup>18</sup>

More recently, an increasing number of tribes have agreed to partnership arrangements with the Ministry of Education. These are a response by iwi to the Ministry to work collaboratively "...towards a more shared understanding what each might contribute to the partnership...and how this might influence improving Māori education outcomes".<sup>19</sup> The partnership arrangements are established in varying configurations of tribal authority such as tribal councils,<sup>20</sup> education authorities or company's.<sup>21</sup> Overall it has been a flax-root approach in the hope of negotiating durable solutions. As a result the various tribal strategies do not subscribe to a 'one size fits all' approach. The

‘Iwi Education Plans’ or ‘Iwi Partnerships’ have evolved out of tribal aspirations, needs and concerns many of which parallel national priorities.<sup>22</sup> These include increasing the levels of student achievement, developing quality education relevant to the community, ensuring good school governance and management, and making certain teachers and principals are well prepared. Iwi partnerships with the Ministry of Education and the development of iwi education strategies have encouraged a number of foci to evolve.

### **Community Focus**

One is a community focus where the process of tribes identifying the priorities in education for their community is as important as the priorities themselves because it has involved extensive consultation. Some communities are located in isolated rural areas where high unemployment and low income are the norm. Coming together to set the overarching education goals for their community has led to increased interest, participation and expectation.

### **Education Provider Focus**

Increasingly tribal communities have looked to education providers to assist in driving their initiatives. This has encouraged schools, teachers and boards of trustees to identify their professional needs and to initiate relevant professional development. In some cases school structures have been reorganised to meet community needs. Where this has occurred, increased collaboration between schools has led to the rationalisation of teacher strengths and experience, the sharing of resources, expertise, knowledge and skills. National Internet Communication Technology (ICT) networks between Māori immersion schools, Māori boarding schools and rural secondary schools has offered online teaching through high speed internet connections and video conferencing.

### **Iwi/Hapu Focus**

An iwi/hapu focus recognises that the strength of an education initiative grounded in the community is not isolating the ideas and thoughts about education from tribal realities and aspirations. Education is considered within a broad tribal development framework, a holistic and integrated method to planning that avoids the fragmented sectorial approach favoured by governments. One North Island tribe for example has aligned the development of their education plan alongside their Treaty of Waitangi claims process<sup>23</sup>. In other tribal areas, strong linkages have been maintained between tribal councils and schools evident in education strategies that correspond with tribal aspirations and manifest in school programmes. Often the strategies are linked to incorporate the local environment - (coast lines, rivers, lakes, mountains) and community economic ventures (fisheries, agriculture, horticulture and aquaculture). Thus tribal education plans are framed in a long-term vision that is generational, rather than the short-term politically inspired durations favoured by governments.

### **Relevant Curriculum Focus**

Education strategies that correspond with tribal aspirations are also expressed in a focus on the curriculum. In the past the national curriculum offered a framework so that tribal knowledge, language (local dialect and idiom) and cultural values (Kahungunutanga) could be incorporated to better reflect the community goals. The new draft curriculum promises to offer the same. In some districts schools have been encouraged to utilise local assets as part of the school resources such as tribal experts and the natural environment. As one Principal of a rural school explained:

‘If you want to talk about native bush or Tane Mahuta<sup>24</sup> or Tangaroa<sup>25</sup>, it is right at our back doorstep...when we talk

about maunga (mountains) it is right there...when we talk about awa it is right behind the school'.<sup>26, 27</sup>

### **Governance Focus**

Some tribal communities have overcome difficulties with recruiting and selecting suitable Board of Trustees members by having schools form clusters served by a single board. This seems to work where commonalities exist in the schools and community through tribal membership. In this context there are instances where parents have had some of their children enrolled in the local kura kaupapa (Māori medium) and others enrolled in the local mainstream (English speaking) school down the road.<sup>28</sup>

### **Accountability Focus**

Where there is a substantial level of tribal and community involvement this has contributed to a sense of 'buy-in' or 'ownership' in terms of supporting and/or implementing their decisions contained within education plans. Although the extent to which this has happened differs between tribes. Tribes consider themselves accountable in so far as making decisions regarding the education pathways for their constituency and wider community. The Ministry of education is held accountable to ensure that community initiatives prevail and to minimize official barriers that threaten to undermine them. However, the extent to which the Ministry has supported community education initiatives is dependant on whether the initiative corresponds with government priorities.

### **Crown/Iwi Relationship Focus**

The focus on Crown/Iwi relationships in education tends to be described in terms of the principle of partnership. Traditional leadership has provided a significant leverage for Crown /Māori interaction and partnership in the development of education imperatives. Since 2001 Tumu Te Heu Heu and Ngati

Tuwharetoa, have hosted several national and regional Māori education forums, Hui Taumata Matauranga, aimed at planning pathways for Māori education advancement. In 2001 the Forum unanimously adopted a framework for the advancement of Māori education proposed by Professor Mason Durie based on three broad but concurrent goals; to live as Māori, to actively participate as citizens of the world and to enjoy good health and a high standard of living. A set of guiding principles suggests how these goals might be reached in terms of best outcomes, integrated action and the principle of indigeneity.<sup>29</sup>

Perhaps influenced by these goals and other events at national and regional Hui Taumata at least nine tribes have entered into formal arrangements with the Ministry of Education by signing a Memorandum of Understanding.<sup>30,31</sup> This is a relationship viewed by iwi as one that reflects the partnership principle they consider critical to the long term success of iwi education initiatives.<sup>32</sup> Each partnership has its own approach and plan and offer opportunities to coordinate and integrate education services. For example, all the partners are piloting the Community Based Language Initiative, others are variously involved in computers in homes, implementing the Youth Mentoring initiative, locally based schooling improvement initiatives and improving teaching practice.<sup>33</sup>

Some tribes, however, have chosen to remain outside of any formal arrangements with the Ministry preferring instead to argue that since the Treaty is the key instrument that defines Crown/Iwi relationships, an MOU is therefore unnecessary. Others suggest that by developing education plans and other strategies, tribes are simply assisting the government with their core business<sup>34</sup> so an MOU makes little difference. In any event, the Ministry's role is considered by tribes to be one that supports a tribal focussed approach to education through assisting with resourcing, accessing technology, providing expertise and

adjusting accountability measures that take account of tribal perspectives. Such accountability measures include supporting the development and implementation of iwi cultural standards in schools.

### **DEVELOPMENT OF IWI CULTURAL STANDARDS – WHAT ARE THEY?**

What exactly are iwi cultural standards and what is the process involved in generating them? Cultural standards have always been held as a significant value within Māori tradition associated with quality and excellence. The Ngati Porou meeting house Te Hau ki Turanga provides a 19<sup>th</sup> century benchmark for art against which contemporary practices in whakairo rākau and kowhaiwhai may be measured. Biennially Te Matatini offers an opportunity for tribes to demonstrate excellence and quality in the art of contemporary composition and practice in language, music and dance. For rangatahi, Ngā Manu Kōrero sets a contemporary measure of standards in the art of oratory. The Māori made mark is a standard of peer review across all the creative arts associated with the Māori language, composition, oratory, art practice and literature.

Like the approach taken by tribes in initiating education plans, there is no single approach adopted by iwi in the development of cultural standards in education. Nor is there a single definition regarding what constitute cultural standards for any one tribe. That is the task of each iwi according to their priorities and in light of other tribal imperatives. The processes tribes have used and the pathway to developing iwi cultural standards differ and are at various stages of development or implementation. Some tribes have chosen to adapt international models to inform their processes, or as a basis for their plans. In particular, the work of the Assembly of Alaska Native Educators.



Over a period of a decade Alaska Native educators have produced sets of standards that offer schools and their communities' ways to measure their effectiveness in providing for the educational and cultural wellbeing of the students in their schools. The standards are predicated on the assumption that grounding in the heritage language and indigenous culture specific to a place is fundamental to the cultural health and wellbeing of students and communities who live or are associated with that place.

Rather than producing standardization in the manner of the Bush governments 'No Child Left Behind' policy <sup>35,36</sup> by contrast Alaska schools and their communities are encouraged to develop appropriate standards that accommodate local circumstances. Such circumstances include the rich and varied cultural traditions still practiced in communities throughout Alaska. In other words, there is an emphasis on connecting what students experience in their lives out of school with what they experience in school. Rather than prescriptive, the standards are described in ways approximating guiding principles with sets of indicators that can be adapted to fit local needs. By way of example, one of the cultural standards is the principle of culturally knowledgeable students. The expectation is that these students are well grounded in the cultural heritage and traditions of their community. Among seven listed indicators that measure whether students have met this cultural standard is their ability to recount their family genealogy and history.

I have already mentioned that tribes involved in developing or implementing iwi cultural standards for schools are at various stages along the way. For example, Whanganui are well advanced and in the process of implementation. In consultation with the Ministry of Education, Ngāti Kahungunu is in the early stages having just completed a scoping exercise and Project Plan aimed at developing Kahungunu cultural standards specifically

for primary schools. There are a number of factors the team charged with scoping and drawing up the Project Plan had to consider and keep in mind. The first was that the Project Plan should link with the Kahungunu strategic direction as outlined in the 25 year Plan the integrated principle Professor Mason Durie talks about. This means integrating the cultural standards Project with other tribal imperatives such as the Kahungunu health strategy, the language strategy and government initiatives like the Community Based Language Initiative (CBLI).

A second factor to consider is what is already known about the status of Māori education in Ngāti Kahungunu and what is not known. For a start what is known is that approximately 4% of all Māori children in the rohe are enrolled in 7 Kura kaupapa and there are 167 primary schools within which the other 96% are located. In the primary sector the dearth of information regarding the participation and achievement levels of Māori children is a concern.<sup>37</sup>

According to NCEA results, Hukarere and St Josephs Māori Girls Colleges (where an identity as Māori is a primary value) are among the top 3 secondary schools in Hawke's Bay.<sup>38</sup> However, participation and achievement rates of students in mainstream secondary schools mirror national statistics and there is evidence of a crisis in public secondary school retention rates from Y9.<sup>39</sup>

A third factor to keep in mind is what is known about the role of whānau, their aspirations and realities. A decade of consultation within Ngāti Kahungunu has consistently highlighted the importance Māori parents and whānau place on the benefits of a dual heritage. They are adamant their children should be exposed to the best of all worlds and that Ngati Kahungunu language, culture and history should be the basis by being included in the school curriculum.<sup>40</sup> Whānau aspirations are no different to those

found elsewhere; that their children do well, finish school and go on to tertiary education. It is for this reason that strengthening whānau/ school relationships is a priority identified as a key platform of the Kahungunu Cultural Standards Project Plan. The realities of whānau within the rohe are represented across the full spectrum of Māori society from whānau who are highly dysfunctional to whānau strong and healthy, from those alienated from marae and or other Māori contexts to those who remain fully involved.

An important consideration is keeping in mind the major aim which is an outcome whereby schools in the rohe are delivering education programmes that are infused with Ngāti Kahungunu history, language and culture. This alone raises many of the questions I raised earlier about knowledge, access to knowledge, what counts as knowledge and who decides? What would a relevant curriculum look like? What are the implications concerning the availability of resources and the intellectual property rights of hapū? Other questions include what is the role of the whānau, local marae and hapū? Are teachers culturally competent? If not what professional development would be required and whose responsibility would that be? Are pre-service teachers culturally competent, and if not what is the responsibility of Colleges of Education to prepare teachers for schools in the context of Aotearoa New Zealand generally, and Ngāti Kahungunu in particular? All of these issues and many more will have to be worked through as the strategy develops and takes shape.

In any event the formulation of an iwi cultural standards strategy must take account of; the role of tribal experts and other relevant advisory groups; the need for multiple stakeholder and end-user consultations (teachers, whānau, education sector, hapū etc.); the importance of research and analysis; managing curriculum and resourcing issues and a timeframe that is realistic.

Sir Robert Mahuta once said ‘any process that does not take Māori values and attitudes into account will have a long, slow road to travel’.<sup>41</sup> The process of deliberations around policies and programmes that shape education in Aotearoa depends on ensuring a Māori voice is heard and how we walk the tightrope between Pakeha expectations and tribal aspirations. For the most part cultural standards are being devised to complement rather than necessarily replace what it is we expect Māori children to know, to do and to be in the context of this nation. It is a strategy that seeks, among others, to infuse the curriculum and incorporate the experiences of a Māori/ iwi way of life. A way of life that includes, as Pat Hohepa explains:

‘... a way of acting, thinking and feeling; of attitudes to language, traditions and institutions; of shared values and attitudes to people, places and things, to time, the land and sea, the environment, life and death.’<sup>42</sup>

So what are the challenges? At a regional Hui Taumata held in Palmerston North recently, one of the local principals of a school renowned for the positive contributions this school makes to Māori education asserted that the advancement of Māori education requires honesty and courage. Being truthful she suggested takes courage. It takes courage for schools to admit the truth about what they do, the extent to which they account for Māori children and, if need be to commit to doing something about it. It takes courage for whānau who are experiencing it, to admit dysfunction, seek help and devote time to supporting their children and local school by active participation. And it takes courage for the large number of teachers in our schools to be truthful about their lack of knowledge about Māori children and commit to making a difference.

The implications for Colleges of Education across the country are profound. Demographic trends point to a significant Māori

population by the year 2050. Māori numbers are growing at a faster rate than non-Māori and it is projected that by then Māori will make up about 21 percent of the total New Zealand population.<sup>43</sup> Combined with estimated growths in Polynesian populations there will literally be a ‘browning’ of the nation. How we prepare for the future of this nation in the education sector requires courage, truth and vision. Indigeneity in terms of Māori language, culture, history, flora and fauna are the features that define Aotearoa New Zealand from any other place on earth. They are the things that make us unique. The challenge is whether there is the maturity and the will to take cognisance of a substantial Māori population in the near future and the implications of this for the way we prepare our teachers; to recognise the importance of Māori language, culture and history which define us from the rest of the world by infusing these in school programmes; and whether we have the vision and fortitude at this moment in time to plan for such a future.

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<sup>1</sup> King, M. (Ed.). (1978). *Tihe Mauri Ora: Aspects of Māoritanga*. Methuen New Zealand Ltd.

<sup>2</sup> See for example, the Whanganui Iwi Education Authority.

<sup>3</sup> Bourdieu, P. (1999). Site Effects. In *The Weight of the World: Social suffering in contemporary society* (pp. 123-129). Stanford, California: Stanford University Press.

<sup>4</sup> Ibid.

<sup>5</sup> For a more indepth discussion on the failure of state schools to capture Māori interests see Smith, G. H. (1990). Taha Māori:Pakeha Capture. Political Issues in New Zealand Education: Second Edition. J. Codd, R. Harker and R. Nash. Palmerston North, Dunmore Press: 183-197.

- <sup>6</sup> Giroux, H., & Aronowitz, S. (1985). *Education under siege*. London: Routledge & Kegan Paul.
- <sup>7</sup> An example is the decision by the NZ Olympic and Commonwealth Games committees to enlist the services of Amster Reedy as the cultural advisor for the teams. As an expert in cultural matters, his role was to ensure the appropriate standard of conduct of cultural values, customs, and icons specific to Māori and New Zealand in providing for the wellbeing of the New Zealand team.
- <sup>8</sup> Law Commission. (2001). *Māori Custom and Values in New Zealand Law*. (Study Paper 9 ed.). Wellington: The Office of the Law Commission.
- <sup>9</sup> Durie, M. (1998). *Whaiora: Māori Health Development* (Second ed.). Auckland: Oxford University Press.
- <sup>10</sup> Current figures show that 7% of Secondary school teachers are Māori compared to 79% who are Pakeha.  
<http://educationcounts.edcentre.govt.nz/>
- <sup>11</sup> M.O.H. (2004). *Child and Youth Health Toolkit. Ensuring access to health care services including well child and family health care, and immunisation*. Wellington: Ministry of Health.
- <sup>12</sup> Appiah, K. A. (2005). *The Ethics of Identity*. Princeton: Princeton University Press.p114.
- <sup>13</sup> Ibid. p150.
- <sup>14</sup> Words in italics and parenthesis are the authors emphasis.
- <sup>15</sup> Ibid. p153.
- <sup>16</sup> Asante, M.-K. (1993). Multiculturalism without Hierarchy: An Afrocentric Reply to Diane Ravitch. In F. J. Beckwith & M. E. Bauman (Eds.), *Are You Politically Correct? Debating America's Cultural Standards* (pp. 185-194). Buffalo, New York: Prometheus Books.p193.
- <sup>17</sup> See (Asante, 1993).

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- <sup>18</sup> Waaka, R., Hapeta, D., Kuiti, N., & Royal, T. (2000). *Whakatapuranga Rua Mano: Generation 2000 celebrating 25 years*. Otaki: Resource Centre Te Wananga o Raukawa.
- <sup>19</sup> M.O.E. (2005, 08 Dec 2005). Iwi Education Partnerships Fact Sheet. *Strengthening the Ministry's response to the education needs of Māori* Retrieved 4/8/06, 2006, from [http://www.minedu.govt.nz/print\\_doc.cfm?layout=document&documentid=7394&inde..](http://www.minedu.govt.nz/print_doc.cfm?layout=document&documentid=7394&inde..)
- <sup>20</sup> Gerritsen, J. (2000, 7 August 2000). Whaia te iti kahurangi: Strive for the ultimate, is happening everyday. *Education Gazette, Vol.79*.
- <sup>21</sup> Te Tapuae o Rehua has partnerships with tertiary institutions. MOE is therefore indirectly involved as the government funding agency for tertiary institutions.
- <sup>22</sup> Ibid.
- <sup>23</sup> Walley Penetito, Nga Pae O Te Maramatanga International Writing Retreat, Solway Lodge, 7-13<sup>th</sup> June 2006.
- <sup>24</sup> Māori deity of the forest
- <sup>25</sup> Māori deity of the sea
- <sup>26</sup> Reference by tribes to the names of the local mountain, river, ocean or forest are used as a metaphor for identity as a member and descendant of that tribal group.
- <sup>27</sup> Ibid.
- <sup>28</sup> Ibid.
- <sup>29</sup> Durie, M. (2004, February). [\*Public Sector reform, indigeneity, and the goals of Māori development\*](#). Paper presented at the Commonwealth Advanced Seminar, Wellington, NZ.
- <sup>30</sup> As at August 2006 the nine partnerships are- Te Reo o Te Taitokerau; Tuwharetoa Māori Trust Board; Te Runganga o Ngati Porou; Te Runanga o Turanganui a Kiwa; Te Runanga o Ngai Tahu; Tuhoē Education

Authority; Hauraki Māori Trust Board; Te Runanga o Te aw Tupua o Whanganui; Te Runanga o Ngati Whatua.

- <sup>31</sup> M.O.E. (2005, 08 Dec 2005). Iwi Education Partnerships Fact Sheet. *Strengthening the Ministry's response to the education needs of Māori* Retrieved 4/8/06, 2006, from [http://www.minedu.govt.nz/print\\_doc.cfm?layout=document&documentid=7394&inde..](http://www.minedu.govt.nz/print_doc.cfm?layout=document&documentid=7394&inde..)
- <sup>32</sup> Gerritsen, J. (2000, 7 August 2000). Whaia te iti kahurangi: Strive for the ultimate, is happening everyday. *Education Gazette, Vol.79*.
- <sup>33</sup> M.O.E. (2005, 08 Dec 2005). Iwi Education Partnerships Fact Sheet. *Strengthening the Ministry's response to the education needs of Māori* Retrieved 4/8/06, 2006, from [http://www.minedu.govt.nz/print\\_doc.cfm?layout=document&documentid=7394&inde..](http://www.minedu.govt.nz/print_doc.cfm?layout=document&documentid=7394&inde..)
- <sup>34</sup> I would like to acknowledge Kym Hamilton for her insights around this discussion.
- <sup>35</sup> Bracey, G. W. (2005). The Seven Deadly Absurdities of No Child Left Behind: Arizona State University. See Also: Maaka, M. (2005). Reading, 'Rithmetica, and Raccoons': The Reality of NCLB in Hawaii. *The June Issue of No Child Left. Vol III, Number 6*. See Also: Maaka, M. (2006, May 8). Please Say No To SB 3059 ( and any future manifestation of it!). *The Honolulu Advertiser*.
- <sup>36</sup> At the 2005 Hokowhitu Lecture, Professor Margaret Maaka and her team from the University of Hawaii described the detrimental effects of the No Child left Behind policy that subjects every child in America including Hawaiian children to Eurocentric standardised tests formulated in mainland USA.
- <sup>37</sup> The Ministry of Education is implementing the collection of iwi affiliations of students in early childhood centres, schools and tertiary education organisations. This information will also be attached to schools using a computerised student management system.
- <sup>38</sup> Ngāti Kahungunu Iwi Incorporated Matauranga Board Meeting, 28 July, 2006 Hastings.



- <sup>39</sup> Tomlins Jahnke, H. (2003). *Ko te Amorangi ki mua: Profile of Māori Education in Ngāti Kahungunu & Ngāti Kahungunu Iwi Mātauranga Plan 2003-2005*. Hastings: A report to the Ministry of Education for Ngāti Kahungunu Iwi Incorporated. See Also: Tomoana, J. (2005). *Ngāti Kahungunu Education Profile*. Hastings: Peak Learning.
- <sup>40</sup> Jackson, M., Pitman, M., & Ruru, M. (1999). *Ma te Rango te Waka ka Rere: The Report of the Ngāti Kahungunu Constitutional Review Committee*. Hastings: Ngāti Kahungunu Iwi Incorporated.
- <sup>41</sup> King, M. (Ed.). (1978). *Tihe Mauri Ora: Aspects of Māoritanga*: Methuen New Zealand Ltd.p8.
- <sup>42</sup> Hohepa, P. (1978). Māori and Pakeha: The One-People Myth. In M. King (Ed.), *Tihe Mauri Ora: Aspects of Māoritanga*: Methuen Publications Ltd.p99.
- <sup>43</sup> HBDHB. (2005). *Māori Health Quarterly Monitoring Report*: . Hastings: Hawke's Bay District Health Board.



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# MĀORI MENTAL HEALTH

*Past Trends, Current Issues, and  
Māori Responsiveness*

*Te Kani Kingi*

This paper was presented at the Te Mata o Te Tau “Oteha” Lecture Series on June 10, 2005, in Auckland.

## INTRODUCTION

The current problems in Māori mental health are well documented. Māori rates of admissions continue to exceed those of non-Māori and are similarly matched by concerns over service utilisation, how they are accessed and the patterns of Māori admissions. For many Māori, initial contact with a mental health service is through the justice system, via the police or welfare services, and under compulsion. Due in part to this, the problems tend to be more acute, often more difficult to treat, and accordingly result in outcomes that are less positive and more difficult to manage.<sup>1</sup> Studies have further revealed that Māori are over-represented in acute disorders, and are almost twice as likely to be readmitted when compared to non-Māori.<sup>2</sup>

Heavy drug use amongst young Māori, particularly cannabis, has also led to a dramatic increase in drug-related disorders.<sup>3</sup>

Psychosis and alcohol and drug abuse account for almost a third of first admission. Māori readmission rates for affective disorders and psychotic illness are 36 percent for women and 75 percent for men higher than corresponding non-Māori rates.<sup>4</sup> Schizophrenic psychosis is currently the second most common cause of admission for Māori males and are almost twice the rate of non-Māori.

Suicide, a problem that was almost unheard of in traditional times, increased by an alarming 162% during the 1980s and continues to have a dramatic effect on Māori communities.<sup>5</sup> More recently, problems associated with the use of meta-amphetamine have received considerable media attention, and, while information on its use is not extensive there is evidence to suggest it is becoming increasingly problematic for Māori in particular.<sup>6</sup>

Due to the extent of these problems and the publicity that often surrounds mental illness one could reasonably assume that these issues have always been a feature of Māori society, that in fact Māori are somehow genetically pre-disposed to mental illness, or that perhaps cultural factors are to blame. The mere fact that mental health problems disproportionately affect Māori provides a reasonable basis for this for this assumption and that perhaps solutions should focus on correcting generic flaws or negative cultural behaviours.

However, there is little evidence to support either of these hypotheses, and in fact there is a considerable pool of research linking Māori culture (a secure identity) to positive mental health. Moreover, that mental health (or mental ill-ness) is a relatively recent phenomena and that historically Māori were viewed as a people of some considerable mental stability. Further, and while familial factors are sometimes used to explain

the development of mental health problems (at an individual level) there is little to support an ethnic or racial bias.

When considering the structure and content of the presentation, I was very much tempted by the need to describe how bad things are, what problems exist, and what future concerns could be anticipated. Certainly, there is considerable evidence to assist with this and to show the extent to which mental health problems now affect Māori. In this regard, there is little doubt that mental health remains the single most significant threat to contemporary Māori health development.<sup>7</sup>

However, and while appreciating the fact that major problems remain, I've decided to focus on Māori mental health (as opposed to illness), Māori development, and what achievements have occurred. While this is perhaps a more difficult path to follow it is nevertheless important that we reflect on our achievements, what gains have been made, and how Māori have responded to these problems. In this way it becomes possible to reveal the extent to which developments have occurred, to likewise recognise the achievements of those in the past, and why it is important that we continue to develop innovative approaches to mental health promotion, treatment and care.

## **AN HISTORICAL OVERVIEW**

To begin with, and in order to provide an appropriate foundation for this presentation, I've decided to look into the past, and to describe historical patterns of Māori mental health. The available information is not great; however, there is sufficient data through which a broad appreciation of major trends and issues can be established.

As already noted, the issue of Māori mental illness is somewhat of a contemporary phenomena. Historical accounts of Māori

health were typically focused on physical health problems. Indeed, and toward the end of the 19<sup>th</sup> Century, Māori health was an issue of Māori survival and there were real concerns that perhaps the race would become extinct, and within a generation or two. These ideas were based on sound advice and in particular statistics which showed that the population had decreased by more than two thirds – from an estimated 150,000 in 1800 to a mere 42,000 in 1896.<sup>8</sup>

Introduced diseases, warfare, land loss, and social change were largely responsible for this decline. Goitre, malnutrition, diphtheria, tuberculosis, and measles, were the main threats to Māori health and often had fatal consequences.<sup>9</sup> By 1900, and if mental health problems were evident, certainly they were not the focus official reports, research, or documentation. This is not to say that mental health problems did not exist, though is perhaps a reflection of the fact that other concerns, more lethal and life-threatening, were afforded greater attention and were thus of more associated interest. In any event, and while Māori health problems were significant, it appears that mental health issues were not.

We can only speculate as to why mental health concerns were less visible. As already noted, it may have simply been a lack of interest or a focus elsewhere. Similarly, problems may have gone undetected and due to the fact that Māori were less likely to access health facilities, were typically cared for within the whānau, and therefore not counted within official statistics. Another, and perhaps more likely explanation, is the idea that the prevalence of mental disorder within Māori communities, and around the turn of last century, was extremely low. That is, Māori were simply less likely to be affected by health problems of a psychological nature.

Again, there is insufficient data to say with any certainty what the actual prevalence of disorder was at that time. In any regard, and based on official reports, admissions data, anecdotal accounts, and independent research studies, it would appear that mental illness was not of any great concern to Māori.

In further support of this it is worth noting that one of the first investigations into Māori psychological well-being only took place in the early 1940s and was largely concerned with understanding the apparent lack of mental ill-ness within Māori communities.<sup>10</sup> That is, why Māori seemed less susceptible to mental disorder. Putting aside the obvious difficulties of assigning diagnosis, and the ability of non-Māori researchers to interpret cultural norms, the results of this study reveal a number of interesting findings. The first is based on observations of Māori communities and an analysis of admissions data. In this regard the study showed that the overall incidence of mental disorder, amongst Māori, was about a third that of Pākehā. In terms of major functional psychotic disorders the study also showed that the Māori incidence was about half that of Pākehā. Problems connected to war neurosis showed similar patterns.

When attempting to interpret this information, its significance and implications, a number of theories were put forward by the authors. Of interest was the idea that mental health problems were somehow impeded by cultural structures, particularly the whānau, and that Māori culture offered a protective mechanism, a basic structure through which mental health problems were unable to develop or at the very least unable to take hold.<sup>11</sup>

In addition, and of associated interest, was the inclusion of a rather prophetic quote, a warning of future possible trends that was unfortunately to ring true in the coming years. The authors note:

‘Judging from experience in other parts of the world, we may hazard a guess that the increasing adjustment of the Māori to the Pākehā way of life with its standards and values, morality and behaviour, will bring a tendency for the Māori mental disease figures to approximate more and more to those of the Pākehā population.’<sup>12</sup>

This quote is of interest not only due to the fact that it was made by a non-Māori psychologist, or that it was based on research conducted during the 1940s. But, that it illustrates a clear relationship between culture and positive mental health. Moreover, that cultural decay would have a predictable and negative impact on Māori mental health. Remember, this was at time when Māori mental health problems were almost unknown and decades before terms like colonisation were used to explain contemporary patterns of illness and disease. In 2000 Tariana Turia was widely criticised for a speech which linked Māori mental illness to ‘post-colonial stress disorders’. The mainstream media were quick to act, describing it as racist and ill-informed. Yet it appears that such notions were not based on the ideas of Māori radicals, but could just as likely be traced to the views of non-Māori some 60 years before.<sup>13</sup>

Moving into the 1950s and beyond more reliable and routine information on Māori mental health was being collected. And while this was again based on admissions data it revealed a similar pattern of relatively low incidence.

In 1951 for example, Blake-Palmer reported that the incidence of Māori admissions to psychiatric hospitals was less than half that of the non-Māori population.<sup>14</sup> In 1960, 60 in every 100,000 Māori were admitted for the first time to a psychiatric hospital compared with a non-Māori rate of 119 per 100,000.<sup>15</sup> In 1962, Foster<sup>16</sup> further noted that for both males and females’ lower admission rates for Māori (in all age groups and for most disease categories) could be expected. Psychoneurosis, for example,



accounted for only 7 percent of all Māori first admissions compared with the corresponding non-Māori rate of 21 percent. In addition, the rate of psychosis related to old age was much higher for non-Māori. Alcoholism and manic-depression were also lower. Durie states:

‘...during the nineteen fifties, non-Māori admission rates to psychiatric hospitals were relatively high, mental hospitals were comparatively large and general hospital psychiatric units were few and small. It was the era of institutional care; interestingly, Māori did not feature as significant consumers.’<sup>17</sup>

Other anecdotal accounts were also gathered and as part of the 1996 Mason inquiry into mental health services and likewise revealed similar trends.

‘I worked at Oakley Hospital in the years shortly after the Second World War...There were more than one thousand patients in the hospital...of whom six were Māori.’<sup>18</sup>

## **THE CHANGING PATTERN OF DISEASE**

It is difficult to say with any precision when the current problems in Māori mental health first began. The contrast between what was reported in the 1960s (and before) compared to the 1980s is rather stark and leaves one wondering what must have occurred during this brief period and in order to bring about such a dramatic change in Māori admission patterns. In short, we simply do not know – although there are a number of possible though likely explanations.

The first has already been touched on and concerns the issue of cultural decay or alienation. During the 1950s the second great Māori migration occurred, though this time was not from

Hawaiki to Aotearoa, but from small rural communities to major urban centres. In search of employment, excitement, and opportunities, many Māori were enticed into the cities and quite often did fairly well as jobs were plentiful and entertainment options abundant. However, and as first noted in 1940s, this urban shift and social integration, also lead to cultural isolation and alienation from many of the traditional structures that in past had protected Māori. While many would have maintained cultural ties, networks, practices, and language, distance from traditional lands, marae, cultural institutions, whānau and hapū, would have made things difficult. For many cultural decay was inevitable as was an increased susceptibility to mental health problems.

A second potential explanation is linked to the first and the search for employment during the 1950s. In times of economic growth and prosperity jobs are relatively easy to come by, reasonably well-paying, and fairly secure. However, and during the 1970s, New Zealand experienced a significant economic decline. Two major issues were largely to blame. The first was the dual oil crises during the 1970s and their contribution to a long and sustained period of declining trade. The second occurred in 1973 and when Britain entered the EEC.<sup>19</sup> In the decades prior to this, and up until 1973, New Zealand produced and exported a relatively small range of primary products - lamb, beef, butter, and milk. The country was well suited to this type of economy, the geography and climate was near perfect and resulted in high quality produce.

Importantly however, was the fact that these limited range of goods had a ready market. To the extent that no matter how much we were able to produce, Britain would always be there to purchase what we had and more. This apparently insatiable market ended however, and as Britain entered the EEC during the 1970s. New markets and new products had to be found, and

in the short term at least this proved to be a somewhat fruitless exercise. This coupled with the oil crisis had one major consequence – unemployment.

While the rising rates of unemployment had a detrimental effect on society as a whole, it was particularly devastating for the Māori community. Perhaps not because of ethnic bias (though this is also debatable) but due to the fact that Māori tended to be employed in primary industries – freezing workers, production hands, and associated sectors. Others were employed elsewhere, though typically worked in low skilled and volatile areas – once laid-off the chances of finding alternative employment was limited. This leading some to describe Māori as the “shock-absorbers for the rest of the economy”.<sup>20</sup>

The obvious consequence was particularly high unemployment within the Māori community and the usual problems of low income, poor and overcrowded housing, reduced access to services, compromised educational outcomes, and the beginnings of a cycle of disadvantage and deprivation. While viruses and pathogens require certain conditions to flourish, the consequences of high unemployment (and all that is associated with it) created a perfect incubator for the development of mental health problems. And indeed, there is a significant amount of research to support this.<sup>21</sup> Accordingly, the impact of the economic downturn of the 1970s must be considered as significant when attempting to understand changing patterns of Māori mental ill-ness.

A third potential explanation relies more on anecdotal accounts and the idea that many Māori were in fact misdiagnosed with mental health problems. In speaking with those who worked in the sector during the 1970s, certain themes emerge and in particular how cultural norms were sometimes interpreted as clinical abnormalities. The issue is tricky in that not all so-called

unusual behaviours are linked to cultural nuances – even though the behaviour itself may in fact show strong cultural tendencies or relationships. That is, just because the behaviour is strange or different, and includes cultural references; one should not assume it is typical or related to a particular cultural norm. On the other hand, it is equally important to consider that many behaviours are culturally specific and that what may seem strange or bizarre in one culture may in fact be normal or accepted within another.

A fourth possible reason for increased admissions is again culturally aligned but concerns the way in which mental health services or hospitals were perceived and an historical preference by Māori to care for their own within the whānau. Up until very recently most mental health facilities were located in remote or isolated settings, the buildings were large and often unwelcoming. Many were self-contained communities (complete with farms and shops) and meant that contact with outside world was infrequent. A strategy also designed to placate public fears of the mentally ill and to reduce the apparent risk of contamination.

As a consequence, this mode of care did not appeal to Māori. Barker notes:

‘The Western psychiatric tradition of confining people with a mental health disability was foreign to Māoris, who had always cared for these people in their communities. The Mental Health system was originally established to cater for people to be taken out of society. Society had this fear of contamination from mental disease and also a massive denial that it even existed. These concepts were alien to Māori people whose whānau members suffering from trauma were always included within the whānau, hapū, iwi boundaries and given special status.’<sup>22</sup>

However, and as the process of urbanisation took hold, traditional ties and cultural expectations were weakened. No longer could the whānau be relied upon to care for those in need, some had in fact lost contact with whānau, while for others the distance was too great. If low admissions were a partial consequence of Māori not seeking care then it appeared that by the mid-1970s Māori whānau were more willing to relinquish this responsibility – further contributing to increasing admissions.

A final contributor I would like to touch on concerns all of the issues previously discussed, but focuses on the particular role of behavioural factors. As described alcohol and drug related disorders disproportionately affect Māori and reflect an overall pattern of unsafe and unhealthy consumption. As far as we can tell psychoactive or perception altering substances were unknown in traditional times and while beverages made from the kava root were consumed in many of the pacific islands, kava (nor any other type of hallucinogenic) made it as far as Aotearoa. Yet, today, alcohol has almost become a cultural norm for Māori and appears to be entrenched within many whānau. And, although this can be said for many families, both Māori and non-Māori, it is the pattern of consumption and the manner in which this is done that causes concern. In this regard, the culture of binge drinking, the associated link to other types of substance abuse, and the elevated risk of related social problems, has also done much to create a fertile environment for Māori mental illness.

In the end, and like much of what has been discussed, it is impossible to say with any certainty what caused the transformation from the historical patterns of Māori mental health to the contemporary issue of Māori mental illness. The change was dramatic, though not entirely unexpected given the immense social, cultural, and demographic changes that took

place. The one thing that is certain however, is that a combination of factors are responsible. The relative role each and the extent to which they contribute is not important, what is however is the fact that these dynamic and complex problems require equality as diverse and integrated solutions. Solutions which not only respond to the treatment needs of patients, but consider the socio-cultural context within which mental health and mental illness takes place.

### **A MĀORI RESPONSE TO THE PROBLEM**

Looking back to a previous point in this presentation it was noted that physical health problems were initially of greater concern to Māori and that by the end of the 19<sup>th</sup> century extinction of the Māori race was a very real possibility. The fact that we as a people still survive, live longer, and are more populous than at any other time in our history is an incredible feat and one which deserves some celebration. However, it is important to appreciate that this survival story was based neither good luck nor active government intervention. In many ways it was the result of desperate actions by a desperate people, a desire to ensure continued existence and a refusal to accept what many believed was an inevitable outcome.

In considering these issues, and early Māori responses to these problems, Durie describes three periods of Māori health development, characterised by the individuals and groups involved as well as the particular health issues they faced.<sup>23</sup> The first is set in the early 1900s and reflects on the work of two Māori physicians – Dr Maui Pomare and Dr Peter Buck. While Pomare was the older of the two, they shared many similarities – both were from the Taranaki region and both educated at Te Aute College. Pomare was the first Māori doctor, while Buck was the first Māori doctor to graduate from a New Zealand university. Their similar views on Māori health development is a

point of added interest. To this end, both new that in order to arrest the rapid population decline, an integrated approach was required. One that utilised Māori networks and approaches - public health and health promotion initiatives, as well as political lobbying.

One can only imagine the types of problems they faced and the task in front of them. Certainly the situation must have seemed insurmountable if not entirely desperate – especially given the knowledge that the population was at an all time low, health problems, death and disease were commonplace, and basic drugs not yet developed. Yet, despite this, and not withstanding political ambivalence, their strategies did work, the population did increase, and a platform for Māori health development had been laid. In describing their work McLean notes that:

‘In the six years between 1904 and 1909 they saw to it that some 1,256 unsatisfactory Māori dwellings had been demolished. Further, that 2,103 new houses and over 1,000 privies built. A number of villages had also been moved to higher ground. He notes that all this had been done at the cost of the Māori themselves without a penny of Government assistance or compensation. What had been achieved was due to the personal efforts of Pomare and Buck and a small bank of inspectors.’<sup>24</sup>

Later, the Māori health and Māori Women’s Welfare League were to make similar contributions as did individuals like Te Puia and Ratana. Eventually, the population was no longer under threat, and while new health problems developed, in a similar way Māori have continued to respond to these.<sup>25</sup>

Although there are any number of messages which arise from this discussion, of interest to this presentation is the notion of Māori responsiveness, a desire to take responsibility, and a refusal to accept that health disparities are more or less

inevitable. While it should be stressed that contemporary Māori health issues are not as desperate as they were 100 years ago, there is at least an overall similarity in terms of attitude and how Māori have approached these concerns. In this regard the current problems within Māori mental health show similar patterns in terms of Māori responsiveness and likewise a comparable desire to confront them, to identify solutions, and to ensure that cultural factors are appropriately considered and utilised.

### **MĀORI MENTAL HEALTH SERVICES**

As described, the dramatic increase in Māori mental health admissions during the 1970s (and subsequently) was cause for concern. Not merely due to the fact that the causes were uncertain, but a suspicion that conventional forms of treatment may prove less effective. Or at the very least out of sync with the expectations of Māori mental health consumers.

As an initial response to these problems cultural therapy units (located within mainstream institutions) were developed. Whaiora, at Tokanui Hospital, and Te Whare Paia at Carrington, were amongst the first. Established in the mid-1980s the units did much to highlight the relationship between culture and mental health. And, while individual practitioners had previously explored the idea of culturally aligned interventions – for the first time two entire services, based on Māori philosophies of care, were established. While both were a departure from the more conventional approaches to treatment, these units were in fact consistent with developments elsewhere and in other sectors, particularly education and welfare. A Māori cultural renaissance was well underway and was often underpinned by the notion that a by-Māori for-Māori approach was best.



Despite this, these early Māori mental health services were not always greeted with enthusiasm and were often viewed as being separatist, divisive, and even unsafe. While Te Whare Paia was to eventually succumb to many of these misunderstandings, the outcome for Whaiora was much different – though the challenges for staff no less difficult. Although Whaiora continued to develop as a consequence of the outcomes produced and the quality of care provided other factors were to also play a role.

First, a favourable relationship with both the Waikato Area Health Board and Tokonui Hospital had formed, and although the association was not always harmonious, for the most part serious differences were avoided. The second concerned the support received from the medical staff. The superintendent at Tokonui, Dr Henry Bennett, and psychiatric registrar, Dr Jennifer Rankin, were both Māori and were keen to support the establishment of the unit and so presented a rationale more acceptable to non-Māori clinicians and management.<sup>26</sup>

Coinciding with the Decade of Māori Development and spurred on by the success of these cultural therapy units the late 1980s provided further opportunities for the development of Māori mental health services. The importance of culture as it applied to health was gaining momentum, and mainstream institutions and clinicians were beginning to appreciate the outcome-related benefits.<sup>27</sup> At a national and international level, an indigenous revival was occurring<sup>28</sup> which helped create an environment that no longer viewed ethnic perspectives with quite the same degree of antagonism and scepticism. Demands by Māori for more direct input into health-related activities was becoming more pronounced, various national hui confirming Māori intentions to play a more active role in matters of Māori health and development.<sup>29</sup> The relevance of the Treaty of Waitangi to health had also been recognised.<sup>30</sup>

When the health reforms of the 1990s arrived Māori were therefore well positioned to take advantage of the opportunities presented, to build on previous successes and to become more actively involved in mental health service provision. As a result the 1990s were characterised by considerable growth in the number and range of Māori specific mental health services. As with most developments of this kind, and as demonstrated in other sectors, this growth was not without problems. For one, it was often difficult to determine exactly what was a Māori mental health service or to identify the criteria upon which they should be funded. In addition, and while opportunities for service development were presented, many were frustrated by the apparent attitude of funders – the short-term nature of contracts, the narrow range of tendered services, and inadequate resourcing.<sup>31</sup>

As well, staffing shortages were to develop and similarly impacted on what services were provided and how they were structured. It was thought that Māori mental health services should ideally have a degree of autonomy, exist outside of mainstream settings, and be staffed entirely by Māori. However, the reality was somewhat different in that services attached to or located within the mainstream provided a vital interface for many Māori consumers, as well, access to clinical expertise was more available. A lack of appropriately qualified Māori staff also meant that many non-Māori were employed within Māori services.<sup>32</sup>

To some degree these problems continue, even today, however – they are not issues which have sat un-actioned or without strategies attached to them. In recent years greater numbers of clinically qualified Māori have emerged. As well, and during the 1990s, the nation's medical schools also began to incorporate cultural dimensions into their curriculum. Programmes such as

Te Rau Puawai and more recently Te Rau Matatini have likewise contributed to the Māori mental health workforce by actively encouraging more Māori to consider a career in mental health. Rather than to focus on a narrow range of core disciplines these programme have recognised the need for active and broad Māori involvement within the sector – more psychiatrist and psychologists, but also health managers, support staff, midwives, social workers and nurses.

### **NEW MODES OF CARE**

It is without doubt that workforce issues remain a significant impediment to the development of Māori specific mental health services. However, it is encouraging note that at least problem identification has led to a range of potential solutions and programmes – and that Māori have played a key role in this. The whole issue of workforce development is an unfortunate consequence of an increase in the number of Māori affected by mental-illness. A further appreciation of the fact that the ethnic and cultural composition of the health workforce should at least match that of the client base.

However, workforce needs are also a reflection of an increase in the number of Māori mental health services. In this regard it has often been difficult to define exactly what constitutes a Māori mental health service – accordingly, it is sometimes difficult to precisely count the total number of services available. Despite this, and notwithstanding some problems, the number and range of Māori mental health services has increased considerably since the days of Te Whare Paia and Whaiora. And, in the space of just 20 years, Māori mental health services have moved from a position of being novel or alternative to that of an accepted and integral part of the New Zealand Mental Health Strategy.<sup>33</sup>

As noted, there is sometimes confusion as to the purpose or intent of these services. Initially, they were viewed as racist or separatist and more recently their fundamental purpose has been linked to cultural enhancement. And while many, if not most, include cultural activities or programmes, the rationale behind these interventions has very little to do with culture per se and everything to do with health. In this regard, cultural activities, processes, or interventions are ultimately designed to improve treatment responsiveness and health outcomes. Culture therefore has little place within a Māori mental health service unless it satisfies the more fundamental requirement of improving the lives and well-being of Tangata Whaiora or Māori mental health consumers.

This requirement has in many ways shaped the manner in which cultural activities have been introduced within mental health services – both mainstream and Māori specific. Viewed through a narrow lens, activities such as pōwhiri, which often take place within Māori services, are seen as a simple process of encounter or welcome. However, a deeper analysis reveals that the whole process can also be quite settling, putting the tangata whaiora and their whānau at ease, providing reassurance, and creating an environment which supports recovery and rehabilitation. Tangata Whaiora are often encouraged to play a formal role in this process, either as speakers or kaitautoko. This is of course consistent with Māori custom, however it also recognises the range of skills that Tangata Whaiora possess and affirms the desire to ensure that they are not just idle participants within the process – but rather the focus.

Cultural assessments also feature within Māori mental health services and are used to complement the more usual clinical assessments. In this way a more comprehensive assessment of the problem is possible and the relationship between cultural and

health better understood. As a consequence broader options for treatment and care can be explored.<sup>34</sup>

Kaumātua are now employed within many mental health services and provide valuable support on issues of tikanga and protocol. However, and more than this, kaumātua are a vital link to the local community and can often identify solutions where previously none existed. In some instances they are also better able to engage with Tangata Whaiora, to create dialogue that is more open and which allows for a better understanding of the problem. In the assessment of issues such as mate Māori their advice is also critical.

Te Reo Māori has also been used within mental health services (for a number of years) and as means of engaging Tangata Whaiora. And, while it is accepted that most Māori are sufficiently fluent in Te Reo Pākehā, many are more comfortable conversing in Māori and may reveal a broader and deeper range of issues. Again, assisting with assessment and ensuring that all possible concerns are considered.

Whānau participation is likewise a characteristic of many Māori services. It is in many ways a feature of Māori culture and society and therefore appears within Māori health models. Whānau and the relationships that exist within them provide a base for cultural interaction and likewise a mechanism through which cultural knowledge is transferred from one generation to the next. Within a health service however, whānau participation has a range of additional benefits. Māori are likely to appreciate the advice and support of whānau members, and whānau will often expect to contribute to the treatment and healing process by actively participating in therapeutic activities.

Whānau participation can be particularly useful within mental health services and at the assessment phase. Here they are able

to distinguishing between cultural norms and mental disorder and in furnishing a more accurate picture of the stresses and strains that impact on Tangata Whaiora. These are often issues that clinicians are particularly interested in but are unable to completely appreciate without whānau input.<sup>35</sup> Although access to whānau is sometimes difficult and participation not always recommended – of significance is the potential of whānau involvement and the manner in which this is used to enhance both treatment and outcomes.

For many, these types of processes or interventions are not new and could additionally include activities like waiata, Māori arts and crafts, rongoa and karakia. However, 20 years ago their application to a mental health setting would have scarcely been contemplated. Moreover, their role in promoting health gains would not have been completely understood – if at all.

To this end, Māori mental health services, and in particular the staff within them, have done much to advance the relationship between culture and health. All this despite workforce deficits, inadequate funding, short-term contracting, increasing demand, and recent political comment to suggest preferential treatment to Māori and likewise question the need for alternative approaches. While more services is an imperfect proxy for better services (and certainly significant problems remain) the point is that these providers have continued to evolve and develop, to find problems and identify appropriate solutions. The level of innovation within some services is also worth celebrating and is of interest both nationally and internationally.

## **OTHER DEVELOPMENTS**

Elsewhere within the sector other positive developments have occurred. As far back as 1994 RHA purchasing guidelines identified both Māori health and mental health as two of the four

health priorities.<sup>36</sup> And while this did not always translate into increased funding for Māori it at least provided some policy recognition of the problem. Following on from this the 1996 Mason Report<sup>37</sup> also raised concerns and further assisted with placing mental health on the political agenda. More recently, and within the Ministry of Health itself, a Māori mental health team has been established within the Mental Health Directorate. This was the first Directorate (outside of the Māori Directorate) to contain a specific Māori team.

The work of Māori within the Ministry of Health is difficult to quantify and they are often unfairly challenged for being crown agents – which of course they are. However, we sometimes fail to appreciate the difficult frameworks they are required to operate within – meaning that often their considerable work goes un-noticed or fails to receive the recognition it deserves. To this end it is unlikely that many of the current and past policy changes would have occurred if not for the increasing number of Māori employed within the Ministry. Many of you would be aware that the State Services Commission is currently conducting a review of policies and programmes within the Public Service and to ensure they are based on need, not race.

One suspects that Ministry staff would have bared the brunt of much of this inquiry and required to provide research, rationale and data as to why Māori approaches are needed. It is not too long ago that the Māori mental health portfolio (within the Ministry of Health) was the responsibility of a single individual. And while greater numbers of Māori involved in service provision is an encouraging sign – so is the increasing number of Māori at the policy level.

The establishment of a Mental Health Commission in 1996 can also be seen in a positive light. As an independent entity, part of the Commissions' role is to monitor the implementation of the

national mental health plan. Their *Blueprint*<sup>38</sup> documents assists with this and describes how the strategy should be operationalised. Of interest is the fact that both *Blueprint* documents describe clear benchmarks for Māori services and have done much to further rationalise development of Māori specific mental health services. Also encouraging are routine progress reports which describe the extent to which these obligations to Māori are being met – or otherwise.<sup>39</sup>

Within the research area, the number and range of Māori initiated and designed studies has also dramatically increased. While a number of factors have contributed to this, the establishment of two Māori health research units in 1993 provided considerable thrust and direction.<sup>40</sup> With regard to Māori mental health research, developments have likewise been encouraging.<sup>41</sup> Of particular interest has been the establishment of a Māori research team as part of the national mental health prevalence study. In the past, and with the exception of a few notable studies, “Māori research” was likely to describe “research on Māori”. Typically, these studies were illness orientated, initiated and conducted by non-Māori, and almost always reflected non-Māori priorities and interests. As far as Māori involvement was concerned, participation was largely confined to the role of consumer or respondent with little expectation that information would be shared or used to inform Māori development.<sup>42</sup>

However, active involvement by Māori within this prevalence study is another example of Māori responsiveness to an issue. The Māori research team has incorporated Māori research methods and practices into what is a highly technical and complex research initiative. In a world first, a range of cultural indicators are included within the data set and will assist in shaping the research findings. Of interest to this paper is the fact that Māori involvement (and the collection of cultural indicators)



further strengthens the relationship between culture and mental health and will do much to advance Māori mental health at service and policy level.

## CONCLUSION

In detailing some of the positive developments which have occurred over the past few years I have not concealed the fact that significant problems remain. However, this presentation isn't about what's going wrong, there is ample discussion on that, but it is about what's going right. And, to further recognise the efforts and advances made by those that for many years have worked and struggled within the sector. When attempting to describe the extent to which progress has been made a number of mechanisms can be used – quantitative and qualitative measures, data, statistics, and evaluations. However, a simpler approach would reflect on more pragmatic comparisons, that is, are Māori more likely to receive better care now than in the past. Quite simply, the answer is yes.

In this regard, and when speaking with many who worked within the old institutions one gets some idea as to how far things have advanced. I have already touched on the fact that during 1950s (and prior) admission to a psychiatric hospital would have bared some resemblance to incarceration within a correctional facility. Large, bleak, impersonal, and gloomy the old style psychiatric hospitals did not always provide an environment conducive to health and well-being. Many were situated in isolated rural areas, that, while deemed more therapeutic – further isolated patients from their whānau, friends, and support networks. For a range of reasons (not least of which concerned a lack of psychoactive drugs) admission to a mental hospital often resulted in a life-time sentence. Removed from society, patients were sometimes also relieved of their dignity, hope and for many their fundamental rights.

While the process of deinstitutionalisation has not been without its problems two important measures of progress are worth considering. The first is about recovery and an increased awareness and focus on this. Recovery, of course, has many different meanings and is often something that is quite individual. According to the Mental Health Commission, recovery is an ability to live well in the presence, or absence of ones mental illness.<sup>43</sup> To live well is of course a personal if not abstract concept though recognises personal goals and ambitions, the dignity of people and their right to live as valued members of society. Although there is still much to be done, the emphasis placed on recovery demonstrates a maturing approach to mental health treatment and the fact that health outcomes should coincide the expectations of service users.

The second point is related to the first and concerns the role of consumers within the mental health sector. In the past, and while being the focus of treatment, mental health consumers were more often idle participants within this process. They often lacked information and more critically - control. While there is more to do in terms of consumer involvement, greater participation, at all levels, speaks volumes in terms of our approach to mental health treatment and care, and ultimately what objectives are sought.

These, rather blunt measures of progress are of course not solely attributable to Māori influence. However, it is my belief that Māori have played no small part in shaping these developments. The recovery approach is not inconsistent with Māori beliefs and holistic Māori models of care. Furthermore, the drive toward greater consumer participation likewise has cultural dimensions and reflects notions of *awhi*, *tautoko*, and *manaakitanga*.<sup>44</sup> These concepts are often imbedded within Māori modes of service delivery and have certainly assisted with shifting attitudes, approaches, and basic philosophies.

This paper has attempted to describe some of the positive outcomes of increased Māori participation within the mental health sector. To highlight what challenges exist, but also to describe how Māori have responded to these issues – as we have done in the past, and will continue to do in the future. As noted, any number of measures can be used to illustrate this point – and I have selected but a few. Regardless it is clear that more Māori are involved in mental health research, service provision, clinical and non-clinical roles, policy design, and various leadership positions within the sector. As well, and more than this, Māori have contributed in no small part to the way in which care is delivered - the relationship between culture and health has been strengthened and have spawned innovative approaches to treatment and care. These innovations are of national and international significance and have further implications for other sectors. Is more required - definitely, will the problems get worse - probably, have Māori make a positive differences - absolutely.

One hundred years ago the main threats to Māori health must have seemed insurmountable. Yet, these challenges were met and overcome and it is perhaps with some nostalgia that we reflect on these problems, the manner in which they were addressed, and how Māori actively responded to these challenges. Perhaps in a hundred years from now we may likewise reflect on present days issues and similarly consider Māori responsiveness and how too the problems in Māori mental health were identified, challenged and overcome.

As a final conclusion to this presentation I would like to consider this ancient tauparapara. It was first shown to me by my supervisor and appropriately describes many of the issues considered in this paper – or at least the notion of Māori responsiveness and action.

<i>Whakataka te hau ki te uru</i>	<i>Cease now the wind from the West</i>
<i>Whakataka te hau ki te tonga</i>	<i>Cease also the wind from the South</i>
<i>Kia makinakina ki uta</i>	<i>Let the murmuring breeze sigh over the land</i>
<i>Kia mataratara ki tai</i>	<i>Let the stormy seas subside</i>
<i>Kia hi ake ana</i>	<i>And let the red dawn come with a sharpened air,</i>
<i>he ata-kura</i>	<i>A touch of frost</i>
<i>He tio, he huka, he hau-hunga.</i>	<i>And the promise of a glorious day.</i>

The tauparapara is part of a very old karakia, a chant often rehearsed when Māori gather, and before commencing the business of the day. Essentially, it expresses a hope for better things to come. It may seem un-usual therefore to introduce it at the end of the paper and not at the beginning. However, the main reason for doing so is to illustrate the fact that we have not yet reached an end-point and that the overall journey is likely to continue.

The tauparapara has other implications as well and illustrates that growth and development does not come without effort. Just as a ‘glorious day’ compensates for the wind, stormy seas, and a ‘touch of frost’, so development is just recompense for our personal and collective efforts, a desire to move onward and upward. The tauparapara can be seen to add its own optimism to the area of mental health with the hope that we may one day look back on the issues of today, the efforts made, and the subsequent gains that were achieved. In this regard I hope we respond the way we always have in times of adversity – with dignity, enthusiasm, and a fundamental belief that no task is ever too big nor too challenging. I am certain that wind, rain, and stormy seas will be encountered along the way, but am equally confident that through the efforts of many, and at the end of the day, the outcome will be positive and the promise of a glorious day realised.

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  - <sup>2</sup> Deloitte and Touche Consulting Group, (1997), *National Acuity Review: Final Report on New Zealand's Mental Health Acute Inpatient Services*, Ministry of Health, Wellington.
  - <sup>3</sup> Te Roopu Rangahau Hauora a Eru Pomare, (1995), *Hauora, Māori Standards of Health*, GP Print Ltd, Wellington .p. 156.
  - <sup>4</sup> Other than schizophrenia or drug or alcohol psychosis.
  - <sup>5</sup> Te Puni Kōkiri, (1996), *Ngā Ia o te Oranga Hinengaro Māori – Trends in Māori Mental Health, 1984-1993*, Ministry of Māori Development, Wellington.
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  - <sup>10</sup> Beaglehole, E., Beaglehole, P., (1947), *Some Modern Māori*, New Zealand Council for Educational Research, Whitcombe and Tombs Ltd, Auckland.
  - <sup>11</sup> Ibid p. 243.
  - <sup>12</sup> Ibid p. 243.
  - <sup>13</sup> <http://pl.net/~keithr/thursday2000.html> (21 January 2002).

- <sup>14</sup> That is, 20.61 per 10,000, compared to 47.73 per 10,000 for the non-Māori population.
- <sup>15</sup> Cited in M. H. Durie, (1994), 'Māori Psychiatric Admissions Patterns and Policies', in J. Spicer, A. Trlin, and J. A. Walton (eds.), (1994), *Social Dimensions of Health and Disease New Zealand Perspectives*, Dunmore Press, Palmerston North.
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- <sup>17</sup> Ibid.
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- <sup>19</sup> <http://www.beehive.govt.nz/ViewDocument.aspx?DocumentID=20574> (25 May 2005)
- <sup>20</sup> <http://www.listener.co.nz/default,1651,1627,2.sm> (25 May 2005)
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# MĀORI AND THE ‘MCSCIENCE’ OF NEW TECHNOLOGIES

*Biotechnology and Nanotechnology  
Research and Development*

*Jessica Hutchings, Paul Reynolds*

This paper is based on presentation given at the Te Mata o Te Tau  
“Whanganui-a-Tara” Lecture Series on June 1, 2005, in Wellington.

## **INTRODUCTION**

In February 2005, the authors of this paper attended a symposium entitled “Nanotechnologies in New Zealand: Opportunities and Challenges” hosted by the Foundation for Research, Science & Technology. The symposium presented the opportunity for a range of ‘stakeholders’ to discuss the future potential of nanotechnology. The amusing thing was that the conference presenters were relatively unclear about nanotechnology applications. For ourselves, we were complete novices but believed we needed to offer a Māori and Indigenous response in this fora. Although we had not worked with Māori communities on this issue, we were able to offer a view that was informed by active involvement with our communities on genetic engineering for the last six years. We could see that this new technology was going to be the “next big thing.”

New Zealand's emerging nanotechnology research industry is slowly blooming with rising investment interest by both industry and government. The New Zealand Government clearly sees nanotechnology as a new market arena with promise and potential and has accordingly marked it as a priority research area, necessitating an injection of research funds. Given New Zealand's fledging capability in this area, both public and private collaborations have been made with international research consortiums. It is incumbent on any research team specialising in nanotechnology to collaborate with larger, more capital intensive international nanotechnology conglomerates in order to enter a market that requires vast capital investment. Both public and private research organisations are courting joint ventures with international leaders such as American nanotechnology manufacturer NanoDynamics in order to be a bit-player on a big playing field.

In 2005 worldwide expenditure in nanotechnology is estimated at US\$8.6 billion. The United States alone has set aside US\$3.8 billion for projects using nanotechnology, which is also enshrined in United States law with the passing of President Bush's 21<sup>st</sup> Century Nanotechnology Research and Development Act which guarantees funding and support for nanotechnology research. By 2015 worldwide expenditure is projected to be US\$1 trillion.

With the existing and projected international investment in nanotechnologies, we know with certainty that the applications of this technology will have worldwide impact. The impact of nanotechnologies is considered by the Ministry of Research, Science & Technology to be enormous, as is indicated by their statement that; "Nanotechnologies could be applied in a very broad range of areas – chemical, biological, electronic and engineering – and the range and types of applications envisaged

indicate that nanotechnologies are likely to have much greater implications and impacts on society than biotechnologies.”<sup>1</sup>

This paper presents a critical response to the “McScience” of new technologies, in particular biotechnology and nanotechnology. Within this paper we build on the previous work of other key writers and commentators in this field<sup>2</sup> and discuss some of the critical issues emerging from the platform of new technologies with relevance to Māori, Pacific and other indigenous peoples. Specifically we discuss the reductionist and mechanist nature of western science and examine the manipulative framing and use of language within this scientific paradigm. We also consider the implications of the western science paradigm for Māori, Pacific and other Indigenous peoples.

Within this paper we identify current nanotechnology activities taking place in Aotearoa/New Zealand and build on the Māori discourse with regard to genetic modification to explore and examine issues Māori may face with regard to nanotechnology. Furthermore we provide commentary on nanotechnology with regard to *Papatuanuku* ‘Earth Mother’ and *Te Tiriti o Waitangi* “The Treaty of Waitangi” and examine the impact convergent or “BANG” technologies pose for Māori, Pacific and other Indigenous peoples. To overlook a Māori analysis of new technologies is to limit the intellectual analysis of nano and other new technologies. In fact, it is our Treaty right to provide a Māori analysis to inform the decisions on how this technology proceeds.

## **BIOTECHNOLOGY AND NANOTECHNOLOGY**

What is the difference between biotechnology, incorporating genetic engineering, and nanotechnology?

The term “biotechnology” encompasses any application of discoveries in biology to the production of living organisms and their products, and includes traditional breeding and hybridization techniques that involve genetic modification as well as the recombination of DNA from different species. More specifically, genetic engineering describes the creation and exploitation of transgenic organisms, where recombination of the DNA from unlike species may occur to produce a new transgenic species. Certainly at the point of interference with life and applications that genetically engineer unlike species, Māori, Pacific and other Indigenous peoples have an innate *kaitiakitanga* “guardianship” responsibility that kicks in immediately, with the resolve that the responsibility falls on us to protect the legacy of our future generations and this includes the *kaitiakitanga* “guardianship” of *whakapapa* “geneology”. Recent biotechnology issues that have engaged Māori include such areas of controversy as the testing and commercial production of genetically modified crops and livestock, cloning of animals, patenting of life, human DNA collection and analysis, genetic screening, gene therapies, xenotransplantation, and new reproductive technologies.

Generally Māori have responded with loud and clear opposition against the introduction of biotechnology. The reasoning for general Māori opposition to biotechnology is located in our *tikanga* “cultural” responses made by Māori in the various consultations and surveys of Māori views on the different aspects of biotechnology. Whilst “pro-biotechnology” and vested interest groups have attempted to marginalise these voices, the resistance to biotechnology by Māori has been informed and driven from Māori communities, informed by academic and scientific analysis, informed by Indigenous and international networks, and is primarily a struggle for the upholding of Māori cultural and intellectual knowledge.

## NANOTECHNOLOGY AND NANOSCIENCE

Nanotechnology broadly defined “is the design, characterisation, production and amplification of structures, devices and systems by controlling shape and size at nanometre scale”.<sup>3</sup> Basically, nanotechnology is the atomic/nano-scale manipulation of matter. The applications of this type of technology are broad and include:

- New forms of manufacturing (such as self-assembling materials)
- Development of new materials (eg, new composite materials of high strength/low weight, new conducting materials, “smart” materials that retain their shape or are self-cleaning)
- New or more efficient electronic components and energy storage devices
- Medical applications (eg, therapies, diagnostic devices, bioengineering)
- Environmental applications (eg, water purification, clearing of contaminated sites, sensors)
- Military applications (eg, weapons, armour, sensors).<sup>4</sup>

Nanoscience is the study of phenomena and manipulation of materials at atomic, molecular and macromolecular scales, where properties differ significantly from those at larger scale.<sup>5</sup> The majority of nano-based research undertaken in Aotearoa/New Zealand is concerned with developing understanding of the nanoscience as opposed to the application of the science to the development of the technology.

## **ARE INDIGENOUS PEOPLE CONCERNED?**

For Māori, Pacific and other Indigenous people, nanotechnology is just another technology that has the potential for misuse resulting in the further marginalisation and exploitation of peoples. As with biotechnology, nanotechnology also offers the illusion of control over nature and purports short-term remedies for larger more cultural, political, and social problems in our world. Developed from the epistemology of western reductionist mechanistic science, nanotechnology does not recognise or respect the interconnected and holistic nature of the environment but rather seeks to manipulate matter at the atomic level to achieve “development” and “progressive” advancements. This western science epistemology is markedly different from the interconnected and holistic worldview of the environment held by many Indigenous cultures around the world.

The greatest concern with nanotechnology is the possible convergence of technologies. Māori, Pacific and other Indigenous people around the world have already voiced their deep concern around biotechnologies and genetic engineering. Nevertheless we are facing the technological age where the convergence of these new technologies emerges as a new highly technological and sophisticated form of science. Now, with nanotechnologies operating at the nano-scale level, combined with biotechnologies and genetic engineering operating at the gene and DNA level, and the leaping advances in information technology, this convergence raises serious issues with regard to new initiatives in the fields of medicine, agriculture and food production, and the impacts on the environment in particular.<sup>6</sup>

Overview of Nanotechnology and Relevance to New Zealand  
Internationally and in New Zealand government sectors are leading the research and development in nanotechnology. The motivation for government support in the research and

development of nanotechnology is their desire to hold advantageous positions should nanotech applications begin to have a significant effect in the world economy, hence these governments and countries are able to fully exploit these opportunities. Harper<sup>7</sup> describes this current situation as a global arms race; “You only have to look at how IT made a huge difference to both the US economy and US military strength to see how crucial technology is. Nanotechnology is an even more fundamental technology than IT. Not only has it the ability to shift the balance of military power but also affect the global balance of power in the energy markets.”

*Levels of public investment in nanotechnology are increasing rapidly. Between 1997 and 2002 there was a 503% increase in nanotechnologies investment as is outlined in Table 1.<sup>8</sup>*

**Table 4.1** World-wide government funding for nanotechnologies research and development (US million)

<i>Area</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>
<i>US</i>	<i>116</i>	<i>190</i>	<i>255</i>	<i>270</i>	<i>422</i>	<i>604</i>	<i>710</i>
<i>Western Europe</i>	<i>126</i>	<i>151</i>	<i>179</i>	<i>200</i>	<i>225</i>	<i>400</i>	<i>NA</i>
<i>Japan</i>	<i>120</i>	<i>135</i>	<i>157</i>	<i>245</i>	<i>465</i>	<i>650</i>	<i>NA</i>
<i>Others 9</i>	<i>70</i>	<i>83</i>	<i>96</i>	<i>110</i>	<i>380</i>	<i>520</i>	<i>NA</i>
<i>Total</i>	<i>432</i>	<i>559</i>	<i>687</i>	<i>825</i>	<i>1502</i>	<i>2147</i>	<i>NA</i>
<i>(% of 1997)</i>	<i>100</i>	<i>129</i>	<i>159</i>	<i>191</i>	<i>348</i>	<i>503</i>	<i>NA</i>

It is estimated that Australia invests about A\$100 million (US\$76 million) annually in research and commercialisation associated with nanoscience and nanotechnologies. Furthermore the United Kingdom government in 2003 allocated £90 million over six years to assist industry to harness the commercial opportunities associated with nanotechnologies.

Researchers in New Zealand are involved in a variety of research associated with nanoscience and nanotechnologies. The focus of New Zealand research is concerned with nanoscience rather than the commercial developments. The Ministry of Research, Science and Technology estimates the New Zealand Government's investment in nanotechnologies to be no more than NZ\$15 million (US\$10.5 million).<sup>10</sup>

The MacDiarmid Institute for Advanced Materials and Nanotechnology, which works in collaboration with a range of Universities and research organisations, undertakes most of the nano-scale research in New Zealand. Furthermore New Zealand is just starting to develop its own nanotech based companies. The country's first nanotechnology company Nano Cluster Devices Limited was established in 2003 from self-assembly research undertaken at the University of Canterbury. The Ministry for Research Science and Technology reports that the current focus of New Zealand's research is on studying and producing nanomaterials, particularly those with electronic applications. They believe the nano research in New Zealand is more closely aligned to nanoscience than nanotechnologies as it is directed towards developing reliable methods for creating nano-scale structures and understanding the properties of nanostructures. Given this, the current research and development in New Zealand is likely to be of most immediate use to other researchers rather than rapidly leading to commercial applications of nanotechnologies.

### **CONCERNS WITH EMERGING TECHNOLOGIES – EXAMINING THE PHILOSOPHICAL FOUNDATIONS OF WESTERN SCIENCE**

Some presenters at the “Nanotechnologies in New Zealand: Opportunities and Challenges” symposium viewed all



technologies as being socially constructed, while another presenter used a knife analogy to illustrate the neutrality of tools; stating that a knife could be used to murder or to cut meat. These types of explanations illustrate the diversity of views apparent in interpretations of contemporary science; those that are socially and culturally astute, and those that are mechanistic and intentionally blind. Furthermore Professor Linda Tuhiwai Smith observes that “science” is a site of tension for Indigenous people stating that; “the clash between science and Indigenous knowledge remains constructed around the interests of science”.<sup>11</sup>

The main problem with emerging technologies such as nanotechnology and biotechnology are the philosophies and ideologies that they are built on. Ultimately, these emergent technologies are built from the foundations of reductionist western science. This type of science has been referred to by some as the age of ‘McScience’, where science has been “captured by business and whose integrity is questioned”.<sup>12</sup>

In contrast, at the heart of *tikanga Māori* “Māori culture” and *matauranga Māori* “Māori knowledge systems” are paradigms that provide clear principles for assessing the worth of new technologies. At the heart of the dominant paradigms of Western reductionist science are concepts that are incompatible with *tikanga Māori* “Māori culture” and *matauranga Māori* “Māori knowledge systems” and are also problematic for Pacific and other Indigenous peoples. These concepts and differences in worldview perspectives are discussed further.

## **NANOTECHNOLOGIES AND MĀORI**

The participation of Māori in the new technologies platform has been situated from a reactive standpoint. This position has relegated Māori to passive and non-decision making participants

in the debate, as opposed to being active agenda-setting participants with regard to new technologies. New technologies such as the biotechnologies have been developed from the epistemologies of western science and the ethics of neo-liberal economics. It is from these dominant positions and spaces that the views of “others” such as Māori, Pacific and other Indigenous peoples are asked to provide; “perspectives”, “views” and “assessments” of these new technologies. After almost fifteen years of Māori making comment on the impact of new technologies our views are again sought, this time with regard to nanotechnologies.

One could be well versed on Māori, Pacific and other Indigenous peoples concerns with regard to nanotechnologies by engaging with the numerous reports, writings, academic papers and submissions made by Māori, Pacific and other Indigenous peoples with regard to biotechnology and in particular genetic modification.<sup>13</sup> Many of the concerns raised by Māori, Pacific and other Indigenous peoples in previous debates concerning new technologies are transferable to understanding Indigenous views with regard to nanotechnology.

Furthermore, these Indigenous “perspectives” and “views” concerning nanotechnology we believe can also be applied to converging technologies. The US government refers to this convergence as NBIC (the integration of nanotechnology, biotechnology, information technology and cognitive science) and envisions that; “the mastery of the nano-scale domain will ultimately amount to the mastery of all nature”.<sup>14</sup> NGO group ETC refer to these converging technologies as “BANG”, an acronym derived from Bits, Atoms, Neurons and Genes, which they describe as the basic units of transformative technologies.<sup>15</sup> ETC Group also warn that “BANG” will profoundly affect human security and health as well as allowing cultural and

genetic diversity to be placed firmly in the hands of the convergent technocracy.

From our perspective Māori concerns and those of other Indigenous peoples with regard to nanotechnologies and convergent “BANG” technologies stem from the connection that Indigenous peoples have with the land and in particular for Māori the obligation we have as *kaitiaki* “caretakers, keepers and guardians” of *Papatuanuku* “Earth Mother”. Within a Māori environmental worldview the land is passed to us from ancestors for us to care take and pass on to our future generations. It is from this premise that any technology that impacts on the land and the environment is of relevance to Māori as *kaitiaki* “caretakers, keepers and guardians” of *Papatuanuku*. “Earth Mother”.

There are many other issues that Māori may explore with regard to nano and “BANG” technologies that stem from our cultural paradigms and frameworks. For example nano and “BANG” technologies raise serious concerns with regard to our key cultural concepts, in particular the aspects of *mauri* “lifeforce”, *whakapapa* “geneology”, *tino rangatiratanga* “self-determination”, *whenua* “land”, *Papatuanuku* “Earth Mother”, *kaitiaki* “guardianship” and *ira* “life principle” as well as issues of intellectual property and decolonisation. It has been our observation through engaging with the GM debate in Aotearoa/New Zealand that the assessments of new technologies from our Māori paradigms are relegated and minimised as “cultural or spiritual concerns” and are neither understood nor rated as relevant. Therefore it is not the purpose of this paper to explore the more complicated culturally based Māori concerns of nano and “BANG” technologies as we believe those discussions are for Māori, Pacific and other Indigenous peoples to have in our own spaces with our own cultural protocols guiding the discussion. This will ensure that the space for critically

discussing our cultural values is protected from “outsiders” and their (mis)interpretation of our concerns. What is relevant for the purpose of this paper is to signal the impact nano and “BANG” technologies will have on *Papatuanuku* “Earth Mother”.

### **NANO-AGRICULTURE ON *PAPATUANUKU* “EARTH MOTHER”**

According to the new nano-vision by the United States Department of Agriculture in 2002, agriculture needs to be; “...more uniform further automated, industrialized and reduced to simple functions. In our molecular future, the farm will be a wide area biofactory that can be monitored and managed from a laptop and food will be crafted from designer substances delivering nutrients efficiently to the body”.<sup>16</sup>

The re-organising of natural processes is not a new idea. The Green Revolution was science based agricultural change that had far reaching ecological, social and political effects. The Green Revolution’s purported advantages were not only outweighed but destroyed by the damages it brought about. The “Miracle Seeds” central to the Green Revolution, for example, were touted as instruments of economic progress in developing countries. In most cases, however, their use led to poverty, discontent, and violence among the very people they were supposed to benefit – the rural, predominately agricultural societies.<sup>17</sup> It is concerning that the Green Revolution with all its detrimental effects has recently mutated into the Biotechnological Revolution which has again mutated into the Nanotechnological/Nano-agricultural Revolution.

The new technologies platform and their associated “Revolutions” fail to support the biological diversity of the environment. Rather these new technologies promote an agricultural relationship mediated by mechanistic reductionist

technology. The new technology platform fails to account for the relationship Māori, Pacific and other Indigenous peoples have with the land, who most refer to as their Earth Mother and who Māori refer to as *Papatuanuku*. Furthermore they fail to recognise and respect the interconnected self-ordering and self-reproducing capacity of the environment.

Of great concern to the protection of *Papatuanuku* “Earth Mother” and the environment is the potential impact of nanostructured particles and devices on the environment. Nanoparticles and other throw away devices may constitute whole new classes of non-biodegradable pollutants that scientists have very little understanding of. Although nanoparticles are mini-versions of particles that have been produced for a long time, the larger versions have undergone testing while research into the impact of nano-waste and nanoparticles on the environment is lacking.

### **NANO AND “BANG” TECHNOLOGIES AND *TE TIRITI O WAITANGI* (THE TREATY OF WAITANGI)**

As with biotechnology, in particular genetic engineering, *Te Tiriti o Waitangi* (The Treaty) provides an appropriate framework from which to assess nanotechnologies. The Treaty obligates the Crown not only to take into account the Māori world, but also to actively protect it. These obligations are clearly set out in Article Two, which states: That the Queen of England agrees and consents (to give) to the chiefs, hapū and all the people of New Zealand, the full chieftainship (*Rangatiratanga*) of their lands, their villages and all their possessions (*taonga*). It is from this premise that we argue that The Treaty should be the foundation for all processes regarding nanotechnologies and “BANG” developments in Aotearoa/ New Zealand. We also argue that The Treaty guarantees Māori rights to be consulted, and to make decisions, about what comes into

Aotearoa/ New Zealand. Many Māori stress that Te Tiriti o Waitangi guarantees rights to control what will impact on their well-being, environment and culture.<sup>18</sup> Moana Jackson (cited in Cram) illustrates this point with regard to GM: "...it [GM] is a Treaty issue, it is, but in a sense that it is our right as sovereign people to make our decisions, it has nothing to do with the Crown's obligation to protect us. Therefore, if our people say, we have the right to discuss this [GM] and need the time to do it then the Crown simply has an obligation to acknowledge that call. Not in a sense of wanting to protect us, but because that is a recognition of our sovereign right. So it [GM] is a Treaty issue in that sense. But for me, it is an exercise of our sovereignty to say we have concerns about this, we need to korero [talk] about this, we will do that first".

Aroha Mead also discusses The Treaty with regard to GM. We believe that the arguments that she makes are relevant to The Treaty analysis of nanotechnology. She states:

'How I see it is that the crown has guaranteed Māori certain rights under the Treaty, both Article 2 and Article 3 rights...How I interpret that in the field of genetic engineering is that, the crown has a responsibility to ensure that the programs that it offers to Māori, to reduce disparities, are safe ones. That the technologies and opportunities that they are bringing to Māori, to help Māori, are safe ones. That what they're doing now is not going to create a further detriment to Māori a further generation from now. Because what has been offered is not safe. So I take the view, and it's the view that we put forward in the work we do here at TPK [Te Puni Kokiri, The Government Ministry of Māori Development] is that, unless the crown can assure Māori that the products that come from genetic engineering are safe, and have no risks associated with them, then they are breaching the Treaty. In very simple terms they have an obligation not just to consult, but to look quite seriously at how this particular technology can assist, or

become detrimental to Māori development. They need to have done that research, they need to have worked the issues out, they need to know what the issues are before they even venture into the field.’<sup>19</sup>

The central notion within The Treaty is to ensure Māori control over areas of life that affect our destiny. Many Māori when discussing The Treaty in regard to GM, discussed the need for consideration and decision making to be based on processes that affirm and enact The Treaty. We believe the same would apply to nano and “BANG” technologies. Other areas of concern raised by Māori voices and authors with regard to GM and The Treaty included the right of participation. Angeline Greensill<sup>20</sup> believes that Māori are being excluded from having a voice on GM, which she sees as in direct conflict with The Treaty.

The discussion to come from Māori concerning The Treaty and GM provides important information for scientists working in the nano and “BANG” technologies fields in New Zealand, social scientists examining the socio-cultural impacts and Māori communities dialoguing about these new technologies. The fundamental lessons we can learn from the GM debate with regard to the Treaty are: decision making processes need to affirm and enact the Treaty as well as the Māori right to participate in the development of this technology. Furthermore a mana wahine conceptual framework to assess the impact of new technologies raises the following questions with regard to The Treaty and nano and “BANG” technologies:

- Does the development and implementation of this technology endorse our Treaty rights?
- Has this technology been developed with the full participation of Māori exercising their Treaty of Waitangi right?
- Is the Treaty of Waitangi being used as one of the decision making tools in the development of this technology?<sup>21</sup>

Nano and “BANG” technologies raise some important Treaty issues concerning decision making, participation and the protection of the environment. We suggest that scientists working in the fields of nanoscience, nanotechnology and “BANG” technologies become familiar with these concerns and issues that Māori, Pacific and other Indigenous communities will inevitably raise with regard to this technology. Furthermore we also strongly advise that scientists learn from the GM debate that new technologies raise issues and concerns for Māori and begin to ask what the Article 1,2 and 3 Treaty issues are with regard to nano and “BANG” technologies.

We also caution scientists against the co-opting of selected Māori experts to provide this advice. *Tikanga Māori* “Māori culture” and *matauranga Māori* “Māori knowledge systems” provide clear guidelines for how Māori might conceptualise a set of culturally informed values, practices and knowledge for the issue of biotechnology and genetic engineering. Consultation over the controversial issue of genetic engineering has again exposed the traditional problems of reliance on “selected” Māori experts. Research teams interested in promoting their research, universities conducting this research and government agencies promoting this research seek these “selected” Māori experts to legitimise their work. Yet over and over again consultation with the general Māori public has revealed the same concerns relating to genetic engineering and the use of traditional knowledge, flora and fauna. Dr Cheryl Smith believes there have been two main responses to such consultation with Māori.<sup>22</sup>

We have been told that we must need more education, especially about science. We are told that obviously we don't understand new things. More education of communities needs to happen and the science curriculum in schools needs to change, for example. This has been particularly evident as a response from ERMA representatives who told us at hui that more education was



needed and who also submitted a paper to the incoming government to ask for a budget to educate us. (Within one Māori women's network I work with there are kuia (women elders), doctorate graduates, Masters graduates, lawyers, medical specialists and we have made representations to ERMA).

The ways we think, our philosophies, need to be changed. We have had our traditional stories re-told to fit the new scientific paradigm, we have had findings appearing re-translating and re-explaining their meanings to show that mixing of genetic material is ok, we have been told that the stories where our ancestor transformed into a bird was genetic engineering, that it was a traditional practice.

What we do advise is that scientists move from the laboratories out into Māori communities to begin to dialogue and to genuinely attempt to understand Māori perspectives with regard to new technologies. This requires the simple art of listening, as opposed to feigning listening.

### **LIFE AS INERT AND MECHANICAL**

Much of modern reductionist science is mechanistic and sees life, nature and biodiversity as largely consisting of separate and independent parts. This machine metaphor in biology has its origins as far back as the 17<sup>th</sup> century French philosopher Rene Descartes. This metaphor shapes both scientific thinking and scientific method. "If the animal is like a machine, as Descartes claimed in Part V of the Discourse on Method, then it is made up of clearly distinguishable bits and pieces, each of which has a determined causal relation to the movement of other bits and pieces. But Descartes's machine model is not only a description of how the world operates but also a manifesto for how to study natural phenomena. If I wish to study an animal as a machine, I commit myself to behaving as if the animal can be broken down

into pieces whose identity as pieces is unproblematic and which have a clear chain of causal connections with each other in producing the properties of the whole".<sup>23</sup>

When life is viewed as machine, "an ethical shift takes place – life is seen as having instrumental rather than intrinsic value".<sup>24</sup> Indian physicist Vandana Shiva believes this results in two forms of violence; "First, life-forms are treated as if they are mere machines, thus denying their self-organizing capacity. Second, by allowing the patenting of future generations of plants and animals, the self-reproducing capacity of living organisms is denied".<sup>25</sup>

This mechanistic view of life exhibits the fallacy that science is never wrong and morals and ethics are malleable. This disrespect for life is fundamental to reductionist science. Furthermore biotechnology, nanotechnology and "BANG" technologies are the ultimate expression of the commercialisation of science and the commodification of nature that began the scientific and industrial revolution. The rise of reductionist science has allowed *Papatuanuku* "Earth Mother", nature and the environment to be declared dead, valueless and inert. Consequently this has provided western reductionist science with permission to exploit and dominate nature in total disregard for the social, cultural and ecological consequences. Vandana Shiva<sup>26</sup> argues that the rise of reductionist science is strongly linked with the commercialisation of science and resulted in the domination of women, non-western and Indigenous peoples. This is clear with the marginalisation of Indigenous peoples interconnected and holistic ways of knowing. With commercialisation as the objective, reductionism became the criteria of scientific validity. Hence non-reductionist, holistic and interconnected ways of knowing ecosystems and environments were pushed out and marginalised. Hence the new technologies paradigm, (encompassing biotechnology, in

particular genetic engineering, nanotechnology and 'BANG' technologies) is pushing out the last remains of interconnected ecological paradigms in science by redefining living organisms and biodiversity as "man-made" phenomena valued by its potential to return a profit.

### **THE GENE AND REDUCTIONIST SCIENCE**

Genetic essentialism puts great stock in the individual and resonates with an ideology of possessive individualism.

'Society is now thought to be the consequence, not the cause, of individual properties. It is individuals who make society. Modern economics is grounded in the theory of consumer preference. Individual autonomous firms compete with each other and replace each other. Individuals have power over their own bodies and labour power, in what MacPherson called "possessive individualism." This atomized society is matched by a new view of nature, the reductionist view. Now it is believed that the whole is to be understood *only* by taking it into pieces, that the individual bits and pieces, the atoms, molecules, cells, and genes, are the causes of the properties of the whole objects and must be seperately studied if we are to understand complex nature.'<sup>27</sup>

Reductionist biomedicine concentrates on identifying genetic predispositions and propensities for myriad disorders including cancer, diabetes, and schizophrenia. Geneticists have even tried to identify genes for such conditions as alcoholism, homosexuality and criminality. Focusing on the individual is problematic, however, as it "diverts attention from the real causes, but also stigmatises individuals, through placing the blame for society's ills on people's genes, and through the arbitrary categorisation of the 'normal' versus the 'abnormal'".<sup>28</sup> Leading Māori educationalist Dr Graham Smith calls this the politics of distraction.<sup>29</sup> Furthermore Māori academic Dr Cheryl

Smith describes it as a “deficit view of our community”.<sup>30</sup> Gottweis calls this the “discourse of deficiency,” the “rewriting of life on a subcellular level in terms of 'absences,' of 'improvables' in need of the intervention of genetic technologies”.<sup>31</sup> Suzuki and Knudtson tersely challenge this view stating that the human genome is not “like some sort of genetic garden from which hereditary defects can simply be plucked like so many weeds”.<sup>32</sup>

Hubbard and Wald are also critical of the genetic determinist-driven research agenda. She argues people’s needs could be better served by developing education campaigns aimed at increasing awareness about the importance of a good diet and regular exercise. They state; “providing the economic and social conditions that could enable more people to live healthily, rather than spending time and money trying to find 'aberrant' alleles and to identify individuals whose genetic constitution may (but then again, may not) put them at special risk”.<sup>33</sup>

Although there is merit in the manageability of science for scientists when seen through a reductionist lens, the reality is far more complex, and “the major diseases today are polygenetic and complex, have environmental determinants, and are not approachable by genetic analysis alone as suggested by the reductionist narrative of molecular biology”.<sup>34</sup> Because of this complexity, Hubbard and Wald argue that “tampering with DNA will have unexpected effects, and there is every reason to believe that some of them will be undesirable”.<sup>35</sup>

Reductionist molecular biology, focused on the gene, leads to the increasing management of life by external administrators. A number of authors have written of the future impact on society of this administration of our bodies, including Gottweis<sup>36</sup>, Hubbard and Ward<sup>37</sup>, and Nelkin and Lindee.<sup>38</sup> Nelkin and Lindee suggest, “The future of medicine seems to lie in more aggressive

biological manipulation, rather than in social intervention to change behaviors that promote disease. Increased authority and power are therefore vested in scientists and physicians, who become the managers of the medicalized society"<sup>39</sup> Hubbard and Wald<sup>40</sup> elaborate and state; "That the healthy as well as the ill live under such continuous medical surveillance is in the interest of the medical-industrial complex, and not in ours. Our new fixation on genes can only make us less confident about our bodily functioning and so increase our alienation from ourselves. We need to engage in active debates about the practical consequences of genetic forecasts for our self-image, our health, our work lives, our social relationships, and our privacy".

As a result, Hubbard and Wald make an urgent call for us all to demedicalize our relationship to our bodies and our state of health. Although this urgent plea by Hubbard and Wald was made in 1997, the expansion of medical surveillance and genetic screening and forecasting has continued without much public debate.

### **THE FRAMING AND LANGUAGE OF REDUCTIONIST SCIENCE**

Scientists ask questions they know they can answer or are amenable to their methods. "Science as we practice it solves those problems for which its methods and concepts are adequate, and successful scientists soon learn to pose only those problems that are likely to be solved. Pointing to their undoubted successes in dealing with the relatively easy problems, they then assure us that eventually the same methods will triumph over the harder ones"<sup>41</sup>.

Why do scientists do this? It is important to maintain the veneer of expertise and, more problematic, the ruling paradigm. Mae-Wan Ho explains this charade quite bluntly. "What do most

scientists do when faced with findings that threaten to topple the ruling paradigm? They describe the findings at great lengths in technical language that not even scientists in other disciplines can comprehend; they fail to interpret the findings altogether or interpret them incorrectly, avoid discussing the practical implications, and above all, dismiss incriminating evidence suggesting that what their colleagues are doing could be dangerous. At the same time, they try desperately to paper over the cracks of the crumbling edifice of the old paradigm, and engage in rampant speculations”.<sup>42</sup>

In a similar vein, scientists’ use of particular frames will couch an issue in a particular way. Nelkin and Lindee provide an illustration of such framing of alcoholism. “If defined as a sin, alcoholism represents an individual's flaunting of social norms; if defined as a social problem, it represents a failure of the community environment; if defined as intrinsic to the product consumed, it represents the need for alcohol regulation. But if defined as a genetically determined trait, neither society nor the alcohol industry appears responsible. And if behaviour is completely determined - either by genetics or environment - even the addicted individual cannot really be blamed”.<sup>43</sup>

When explaining the historical incidence of tuberculosis, Lewontin says; “Although one may say that the tubercle bacillus causes tuberculosis, we are much closer to the truth when we say that it was the conditions of unregulated nineteenth-century competitive capitalism, unmodulated by the demands of labour unions and the state, that was the cause of tuberculosis. But social causes are not in the ambit of biological science, so medical students continue to be taught that the cause of tuberculosis is a bacillus”.<sup>44</sup>

And further, in speaking about the bogus crime gene, Kaplan focuses the issue of crime in America on a more meaningful path

stating that: "Rather than attempting to understand why one inner-city youth adopts a life of crime and violence while another does not, we perhaps ought to concentrate our limited resources on understanding why so many more violent crimes per capita occur in the United States than in many other Western nations".<sup>45</sup>

Another source of obfuscation is scientists' use of language, their choice of terminology in articulating science. According to Keller, scientists are language-bound. She states; "The words they use play a crucial (and, more often than not, indispensable) role in motivating them to act, in directing their attention, in framing their questions, and in guiding their experimental efforts. By their words, their very landscapes of possibility are shaped".<sup>46</sup>

Keller describes here how scientists are themselves limited, directed, and guided by the words that they use to think, analyse and describe problems, processes and results of research.

Genetic engineering has fostered and been shaped by a new language. The discourse using this language privileges the gene because of its ascribed function. Genetic engineers seek and patent "functional" or "instrumental" knowledge driven by the notion that knowing how things work will logically lead to ability to make them work more efficiently. This biotechnological goal has shaped molecular biology and transformed its scientists into engineers and entrepreneurs. Identifying and ascribing a function to a particular gene, no matter how faint or weak a connection, is a shrewd and strategic scientific endeavour that can lead to a new viable area of study and investment and thus access to research funding. Language is also used to perpetuate the status quo, where some older discourses are replaced or transformed. Language can be powerful in reproducing certain institutional forms and hegemony, where "older" or "pre-existing" scientific areas are

redefined using more sanitised contemporary language that factors in the positive connotations of “progress” or downplays any inherent “danger.” Gottweis observes that this “progress talk” is a counterstrategy employed to defray resistance. “Social resistance against genetic engineering was met by counterstrategies seeking to establish a framing of biotechnology as an articulation of progress and modernization”.<sup>47</sup>

The language of “risk” is a powerful example of how science is defined and articulated. A number of authors have written on the pervasive nature of risk discourse, including Beck,<sup>48</sup> Crook,<sup>49</sup> Douglas and Wildavsky,<sup>50</sup> Leiss and Chociolko,<sup>51</sup> and Winner.<sup>52</sup> Winner notes “One's initial definition of the problem helps shape subsequent inquiries into its features”.<sup>53</sup> The choice of the word “risk” in biotechnology and nanotechnology research tends to imply that the chance of harm in question is accepted willingly in the expectation of gain. However according to Winner, “this disposition to weigh and compare is not invoked by concepts that might be employed as alternatives to 'risk' - 'danger,' 'peril,' 'hazard,' and 'threat.' Such terms do not presuppose that the source of possible injury is also a source of benefits”.<sup>54</sup> Crook raises another problematic aspect related to risk, that of how to articulate risk discourse itself. “The rhetorical battle over the cultural riskiness of biotechnology is fought along two main axes, one running between “natural” and “unnatural,” the other between “old” and “new.” If “new” and “unnatural” are both risky, it is important to its proponents that biotechnology should not be seen as having both characteristics at once. The ideal, but perhaps implausible, strategy would be to position biotechnology as both “old” and “natural”.<sup>55</sup>

In any event, when decision makers are faced with uncertainty and possible “risk,” Winner suggests the result is, “prudence becomes not a matter of acting effectively to remedy a suspected source of injury, but of waiting for better research findings”.<sup>56</sup>



## **AND IF MĀORI SAY NO, WHAT THEN?**

Ultimately Māori, and other Indigenous peoples, have found that Western reductionist science takes precedence over any resistance to new technologies. Donna Ngaronoa Gardiner sees this as symptomatic of the arrogance of Western reductionist science.

‘In the event of a community saying no to the experiments, Western scientists view that resistance as being based on ignorance and misunderstanding of the projects aspirations. These attitudes reflect beliefs about western racial superiority – that western science knows best – even if the subjects of that science do not consent. This is also a symptom of arrogance and the belief that any innumerable number of experiments can be undertaken in the name of science. The fact that Indigenous populations may not consent because of a fundamental difference in world view is of little consequence to unscrupulous companies and scientists.’<sup>57</sup>

## **CONCLUSION**

The question that immediately comes to our minds with nanotechnology is, “why are we being pushed down another one-way road?” The New Zealand public will not be given any choice in whether New Zealand will engage with nanotechnology. The decision has already been made for us. The government and main research funding body in New Zealand, the Foundation for Research Science and Technology, have already indicated significant investment now and in the future in nanotechnology.

We are a little short on hope of how effective our collective voices can be in stemming the overzealous and reckless rush

toward technological development. We (Māori, Pacific and other Indigenous peoples) have been here many times before. Over and over again our concerns have been voiced. Over and over again our concerns have been marginalised. When we hear comments of the sort voiced at a recent symposium on nanotechnology that describe the technology as “tools” that are neutral, with little regard for the political economy that these tools operate within, we know that we are not being heard.

The “McScience” of reductionist western science such as biotechnology, genetic engineering, and nanotechnology, has evolved from a strong colonialist ideology of “we know what’s best for the rest.” This type of arrogance also applies to the types of applications utilised such as genetic engineering and some nanotechnologies, where “man” (because it often is a man) wields control over nature, where “man” believes in the seeming immortality of humans, and “man” believes that profit takes precedence over everything else.

So how do we move forward to ensure our views and concerns as Treaty partner, as indigenous peoples, as *kaitiaki* “guardians”, as parents and grandparents of our future generations, around new technologies such as nanotechnology are heard?

As hollow and naive as this statement may sound, we believe that there may be an opportunity here for Māori to be proactive on voicing their opinions and views around this new technology. As a fledgling technology, we are in a position as Treaty Partner (not to be subsumed as one of many public interest groups) to be able to influence the direction of nanotechnology applications and provide sound advice, learnt first hand from our disastrous experiences and engagements with the development of genetic engineering applications, on the appropriateness of the different application areas. Central to any developments of this new technology is the urgent need to conduct studies that outline the

impacts of nanotechnology, with particular focus on social, health and environmental impacts.

It is incumbent upon us as Māori, Pacific and Indigenous peoples to stand up and be heard. Our ancestors are counting on us.

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<sup>1</sup> MORST Ministry for Research Science and Technology, 2005, *Nanoscience and Nanotechnologies in New Zealand – Challenges and Opportunities for Research and Policy*. Wellington, Ministry for Research Science and Technology.p8.

<sup>2</sup> In particular we build on the work of Smith 1999, Gardiner 1997, Hutchings 2004, Reynolds 1999, and Mead 1997. This article is also developed in part from the Ph.D. thesis work completed by Dr Jessica Hutchings and Dr Paul Reynolds.

<sup>3</sup> Ibid. p3.

<sup>4</sup> MORST Ministry for Research Science and Technology, 2005, *Nanoscience and Nanotechnologies in New Zealand – Challenges and Opportunities for Research and Policy*. Wellington, Ministry for Research Science and Technology.

<sup>5</sup> Ibid.

<sup>6</sup> ECT Group, 2004 *Down on the farm, the Impact of Nano-Scale Technologies on Food and Agriculture*. Canada, ETC Group.

<sup>7</sup> Arnall Alexander, 2003 *Future Technologies, Today's Choices Nanotechnology, Artificial Intelligence and Robotics; A Technical, Political and Institutional Map of Emerging Technologies*. London, Greenpeace Environmental Trust.p18.

<sup>8</sup> Ibid.

<sup>9</sup> Others includes Australia, Canada China, Eastern Europe, the Former Soviet Union, Singapore, Taiwan and other countries with nanotechnology R&D. For example, in Mexico there are 20 research

groups working independently on nanotechnology. Korea, already a world player in electronics and, has an ambitious 10-year programme to attain a world class position in nanotechnology.

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- <sup>15</sup> Ibid. p6.
- <sup>16</sup> Ibid. p8.
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# FROM INDIGENOUS EXCLUSION TOWARDS FULL PARTICIPATION

*The Māori Experience*

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## **INDIGENEITY**

There are significant differences in the circumstances of indigenous peoples in various parts of the world, manifest by varying degrees of dispossession, different health and education experiences and diverse political relationships.<sup>1</sup> However, although colonisation and globalisation have often undermined indigenous culture and economies, global forces and electronic communication have also provided greater opportunities for indigenous communities to enter a world-wide network and to engage with each other. In that process the commonalities between indigenous peoples have become more apparent.

In defining indigenous peoples in 1949, the United Nations General Assembly noted several characteristics:

‘Among the peoples of the earth, indigenous people constitute a vulnerable group which has long been neglected.

Their social structures and lifestyles have suffered the repercussions of modern development. They have been subject to growing pressure to bring their languages, religions, knowledge, arts and oral traditions, and the other manifestations of their ways of life, into conformity with those of the majority social groups around them.<sup>2</sup>

In the definition, however, the General Assembly had not given weight to indigenous aspirations for self determination and repatriation of resources. Although conforming to wider society was not irrelevant, a primary aim of indigenous peoples has been to regain indigenous values, properties, and language and to exercise a degree of autonomy. Most indigenous peoples believe that the fundamental starting point is a strong sense of unity with the environment.<sup>3, 4</sup> Arising from the close and enduring relationship with defined territories, land, and the natural world, and exemplified by the pattern of Māori adaptation to Aotearoa (New Zealand), it is possible to identify five secondary characteristics of indigeneity (table 5.1).<sup>5</sup>

**Table 5.1** Characteristics of Indigeneity

<i>Features</i>	<i>Key Element</i>
Primary Characteristic: An enduring relationship between populations, their territories, and the natural environment.	An ecological context for human endeavours
Secondary Characteristics (derived from the relationship with the environment): <ul style="list-style-type: none"> <li>• the relationship endures over centuries</li> <li>• the relationship is celebrated in custom and group interaction</li> <li>• the relationship gives rise to a system of knowledge, distinctive methodologies, and an environmental ethic</li> <li>• the relationship facilitates balanced economic growth</li> <li>• the relationship contributes to the evolution and use of a unique language.</li> </ul>	Time Identity  Knowledge  Sustainability  Language

The first secondary characteristic reflects the dimension of time and a relationship with the environment that has endured over centuries; the second, also derived from the environmental relationship, is about culture, human identity, and group structures and processes that celebrate the human-ecological union. The third characteristic is a system of knowledge that integrates indigenous world-views, values, and experience, and generates a framework for a distinctive environmental ethic. Application of that ethic to natural resources provides a basis for the fourth characteristic, economic growth balanced against environmental sustainability. Finally, indigeneity is also characterised by a language so strongly influenced by the environment that it is not spoken as a first language in other parts of the world.

## INDIGENOUS EXCLUSION

Despite differences in the standards of health of indigenous peoples, there are similarities in post-colonial experiences - patterns of disease, socio-economic marginalisation and political impotence. In the eighteenth and nineteenth centuries for example, groups as diverse as Māori in New Zealand, Australian Aborigines, Native Hawaiians, the Saami of Norway, Native Americans and the First Nations of Canada, were nearly decimated by infectious diseases including measles, typhoid fever, tuberculosis and influenza.<sup>6</sup> For the First Nations, smallpox epidemics produced even greater suffering.<sup>7</sup>

Higher levels of morbidity and mortality have continued among indigenous peoples.<sup>8</sup> Indigenous populations generally have lower life expectancy than non-indigenous populations, a higher incidence of most diseases, (e.g. diabetes, mental disorders, cancers) and experience of third world disease in first world nations (tuberculosis, rheumatic fever).<sup>9</sup> Similarly participation in education is often jeopardised by limited access to quality schooling, low expectations, and a failure to secure positive engagement with students and their families.

Recognising the marginalised position of indigenous people, and their exclusion from key societal institutions, four key factors have been recommended for indigenous participation in society and the economy in Latin America. First, since it is the most significant driver of income, more and better quality education for indigenous peoples is critical. Second, improving health status, especially malnutrition in children can lead to better education outcomes. Third social services should be more accountable to indigenous peoples and better attuned to indigenous worldviews and aspirations; and fourth consistent data collection that enables indigenous peoples to be identified is a prerequisite for planning and action.<sup>10</sup>

## **MĀORI DEMOGRAPHIC TRENDS**

As the indigenous people of New Zealand, the Māori experience has not been dissimilar from indigenous populations in other countries. In 1905, the Māori population was estimated at 45,000 and close to extinction. However, not only did it survive, within a century it had become more numerous than at any other time in history. Even though changes to statistical definitions of Māori make it difficult to draw comparisons, there is strong evidence of a substantial and sustained increase in the Māori population. In the 2001 census 526,281 New Zealanders identified as Māori; 85% were classed as urban dwellers.<sup>11</sup>

Although accounting for some fourteen percent of the total New Zealand population in 2001, by 2051 the Māori ethnic population will almost double in size to close to a million, or twenty-two percent of the total New Zealand population. Even more significant, at least for educational planning, by 2051 thirty-three percent of all children in the country will be Māori.<sup>12</sup> By then Māori in the working age group, fifteen to sixty-four years, will have increased by eighty-five percent.<sup>13</sup> Yet although the younger age groups will continue to grow, the population will begin to age, the proportion of men and women over the age of sixty-five years increasing from three percent in 1996 to thirteen percent in 2051.

Like many New Zealanders, Māori are mobile. Following World War II urbanisation resulted in major migrations from country areas to towns and cities and by 1976, more than eighty percent of Māori were living in urban settings, a quarter in the greater Auckland area. Emigration overseas has also become a significant trend, some 30,000 Māori now being recorded as residents in Australia.

## **POSITIVE MĀORI DEVELOPMENT**

From 1984, and for reasons beyond the scope of this paper, the process of dismantling the welfare state began in New Zealand. The new free market approach required radical restructuring of the economy, reduced state expenditure, deregulation and wherever possible the introduction of competition. Driven by economic expediencies that included the removal of state subsidies from the agricultural and forestry sectors, “temporary” stress on all New Zealanders was seen as inevitable. Māori, however, carried an excessive share of the burden. Within five years Māori unemployment more than doubled to over twenty percent and in some areas was higher for school leavers.<sup>14</sup>

But just as the welfare state had a downside for Māori, the free market environment had unexpected benefits. The Māori Economic Summit meeting, the Hui Taumata held in 1984, prescribed a decade of positive Māori development premised on the themes of tribal development, economic self reliance, social equity and cultural affirmation. In keeping with the wider national economic reforms, where a diminished role for the state was being paired with a greater role for enterprise, the new call was for “Māori solutions to Māori problems.” Both the lack of confidence in the capacity of the State to offer positive solutions and a desire to capitalise on existing Māori structures and values, combined to inject a sense of independence and renewed commitment to alternate approaches. Significantly, a sound economic base was seen as a crucial step towards achieving any real social or even cultural survival.

## **MĀORI EXCLUSION**

The main impetus for launching a Decade of Māori Development was directly linked to the marginalisation of Māori people compared to other New Zealanders. To some extent Māori can

still be regarded as an excluded population insofar as there are significant disparities in educational and health outcomes, with lower standards of material wellbeing and lower incomes.<sup>15, 16</sup> But measured against progress over time and Māori participation in non-compulsory education and in the health workforce, it is clear that movement from exclusion towards full participation is in progress.

Moreover, in contrast to the measurement of exclusion, where disparities between population groups based on universal measures are important, the measurement of full participation for indigenous populations requires indicators that reflect participation in the indigenous world as well as in wider society. For most of the twentieth century policies for Māori were essentially premised on attaining equity with other New Zealanders and adopting the same values and world views as the majority population. It was not until 1984, and the launching of the decade of Māori development that the retention of Māori values and culture was seen as integral to socio-economic advancement.

In the new approach, there was a frank rejection of any notion of assimilation. Instead the expectation was that all Māori young people should be able to grow up as New Zealanders and as Māori. Full participation need not mean abandoning a Māori identity. A second point arising from a decade of positive Māori development was the desire of Māori people to develop their own economic and social systems in ways that were consistent with Māori aspirations and priorities. While the State as a provider had certain attractions, seldom was it inclined to recognise Māori preferences. In contrast, in the deregulated environment, large numbers of Māori health, education and social service providers emerged enabling families (whānau), communities and tribes to steer their own courses.

The trend is consistent with article 21 of the Draft Declaration of the Rights of Indigenous peoples:

‘Indigenous peoples have the right to maintain and develop their political, economic and social systems, to be secure in the enjoyment of their own means of subsistence and development, and to engage freely in all their traditional and other economic activities. Indigenous peoples who have been deprived of their means of subsistence and development are entitled to just and fair compensation.’<sup>17</sup>

The twin approaches, retaining a Māori identity while rejecting assimilation, together with a measure of autonomy, self management, and Māori delivery systems, have been important in the Māori journey from exclusion towards full participation. Transformations have been evident in a range of areas, including entrepreneurship,<sup>18</sup> but there has been particular progress in non-compulsory education and health workforce participation.

### **MĀORI PARTICIPATION IN NON-COMPULSORY EDUCATION**

Since 1984 Māori participation in education at all levels has been transformed in two respects. First, the education system has recognised Māori language, knowledge, and culture as core elements of the curriculum. Second, participation rates in non-compulsory education have escalated in an unprecedented manner. While the participation rates are uneven, and many Māori youngsters still remain outside the reach of effective education, there has been a remarkable turnaround. The initial establishment of Māori alternatives such as Kōhanga Reo (Māori language immersion centres) in 1981 have provided cultural attractions and within the mainstream higher Māori participation rates in early childhood education have also been evident, growing by over thirty percent between 1991 and 1993. By 2001 forty-five percent of all Māori children under five years of age



were enrolled in early childhood services, nearly one-third in *kōhanga reo*<sup>19</sup> and by 2005 around 90% of Māori children entering primary school had experienced some form of early childhood education.<sup>20</sup>

For older learners there have also been significant gains. Retention rates for sixteen year olds at secondary school increased from 47 percent (in 1987) to 63 percent in 2003). Between 1983 and 2000 the percentage of Māori students who left school with no qualifications decreased from 62 percent to thirty-five percent, while at the tertiary level, between 1993 and 2004 Māori participation increased by 148 percent. By 2002 Māori had the highest rates of participation in tertiary education of any group aged at twenty-five years and over. Although the significant improvement masked the fact that Māori were still five times more likely to enrol in Government remedial training programmes and three times less likely to enrol at a University,<sup>21</sup> around seven percent of the total university population in 2005 is Māori. But most of the recent tertiary education growth has occurred through accredited tribal learning centres, *wānanga*, which increased enrolments from 26 000 students in 2001 to 45 500 in 2002.<sup>22</sup>

*Wānanga* were formally recognised as tertiary educational institutes in the 1989 Education Amendment Act and they are eligible for funding in the same way as other tertiary institutions. *Wānanga* students tend to be older and more likely to be enrolled in sub-degree programmes, though both undergraduate and postgraduate degree programmes represent a significant part of the offerings of two *wānanga*.

Despite the larger number of students enrolled in sub-degree programmes there has also been a demonstrable increase in the number of Māori with doctorate degrees (since 2000 around

twenty or thirty graduates each year) with a corresponding increase in Māori research capacity.

A major milestone for the New Zealand research community was the establishment of Ngā Pae o te Māramatanga, a centre for research excellence at the University of Auckland in 2002.<sup>23</sup> In addition there are several other Māori centres for research including Māori health research centres, Māori business research, educational research, and an interdisciplinary Academy for Māori Research and Scholarship (Te Mata o te Tau) at Massey University.

The major educational transformations that have occurred since 1984 are summarised in table 5.2.

**Table 5.2** Māori Educational Transformations 1984 – 2005

<ul style="list-style-type: none"> <li>• Rapid uptake of early childhood education</li> <li>• Greatly increased participation in tertiary education</li> <li>• Educational policies recognise Māori aspirations and Māori knowledge</li> <li>• Multiple educational pathways (university, polytechnic, wananga, private training organisations)</li> <li>• Higher participation rates in in sub-degree programmes</li> <li>• Significant research capacity</li> </ul>
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## **MĀORI PARTICIPATION IN THE HEALTH FORCE**

In 1984 the first national Māori health hui was held and the possibility of Māori health delivery systems was raised.<sup>24</sup> Critics were concerned that any move away from conventional medical models of delivery would disadvantage Māori, creating a type of separatism with a lowering of standards. But others argued that

health statistics clearly demonstrated a type of separatism anyway and that a high quality service was of little value if it was not used. Māori were over-represented in almost every diagnostic category and were not gaining adequate access to health services and facilities.

Prior to 1980 there were only three or four Māori health providers and they often had to contend with assumption that all New Zealanders shared the same cultural values, aspirations and history. In contrast, by 2004, there were nearly 300 Māori health providers and Māori language and culture had become more or less accepted as part of the operating norm in schools, hospitals, state agencies, the media, and community centres.

As one way of addressing the disproportionate representation of Māori in most illnesses and injuries, workforce development has become a high priority for improving Māori standards of health. In 2000, Māori made up around fourteen percent of the total population but only five percent of the national health workforce.<sup>25</sup> In order to increase the size of the workforce, two broad strategies were instituted.

First, efforts to recruit more Māori into the health professions have included affirmative action programmes – or programmes that have similar aims. In 1998 for example the University of Auckland launched *Vision 2020*, a programme designed to significantly increase Māori entry into the medical school. In 1984 there were 5 new Māori medical students but by 2004, the number of new Māori entrants had increased to 24.<sup>26</sup> Similar trends have been seen in the qualified medical workforce. From an estimated medical workforce of around 60 in 1984, there are now over 200 Māori medical practitioners across range of specialties, accounting for three percent of the total active medical workforce. In addition scholarships have been offered from a number of sources as incentives to encourage enrolment

in other disciplines such as nursing, social work, clinical psychology and addictions. The number of Māori dentists for example has increased from 4 or 5 in 1984 to 44 in 2005.

A second workforce strategy has been to engage cultural advisors or Māori community health workers to work alongside health professionals, bringing first-hand knowledge of community and a capacity to engage diffident patients. Often the combination has been highly effective though there has also been concern that the two streams of workers – cultural and clinical – have created potential for professional and cultural interventions to diverge. An integration of cultural and clinical dimensions is one of the more pressing challenges facing Māori health care.

While the impact of workforce strategies on Māori health status has not been specifically determined, there have been significant gains in Māori health, especially over the past five years. For non-Māori New Zealanders there was a steady increase in life expectancy at birth over the period from 1985-1987 to 2000-2002. For Māori there was little change for males or females during the 1980s but a dramatic improvement in the five years to 2000-2002. Between 1984 and 2002 the life expectancy increased from 65 years for Māori males to 69 years while for Māori females it increased from 70 to 73 years. Notwithstanding the eight year gap between Māori and non-Māori, in the five years to 2000-2002, the gap reduced by 0.6 years.<sup>27</sup>

## **TRANSFORMATIONS**

These changes and others like them, represent major transformations the extent of which would have been difficult to predict, even twenty years ago. Then, the inclusion of Māori perspectives within health services or in environmental management were exceptions rather than the norm and the conservative call was for New Zealand to have single systems of

education, health and justice based essentially on majority perspectives.

An apparent irony is that Māori were able to assert demands for social systems that supported Māori values and ideals within a market driven environment. The Welfare State had presumed that its duty to Māori was discharged when the worst features of poverty had been eradicated. Being Māori meant being poor, not necessarily being indigenous or being able to live as Māori. Although the economic and government reforms instituted in the 1980s impacted heavily on Māori causing unemployment to suddenly escalate, they were also accompanied by a fresh spirit of independence and a renewed determination to retain those elements of indigeneity that were essential to being Māori in a complex and modern society.

As a consequence, when the twenty-first century dawned, Māori were in a stronger position to live as Māori than they had been two decades earlier.

Although the reformation over the past two decades has not been even, or as extensive as many would wish, it nonetheless represents a series of major transformations. Notwithstanding continuing inequalities between Māori and non-Māori, Māori experience has been radically changed in the direction of:

- Greater involvement in the delivery of social services, including health care
- Improved access to services
- A proliferation of semi-independent Māori organisations
- Higher participation rates in the education system at early childhood and tertiary levels
- Immersion Māori language education programmes from early childhood to tertiary levels
- Significantly raised membership in the legal and health professions

- Escalating entry into the fields of commerce, business, and science
- A major increase in the number of children who are native speakers of Māori
- A re-emergence of tribal groups as agents for Māori development
- The settlement of major historic Treaty of Waitangi claims.

The question now arises as to whether further transformative experiences are needed over the next 10 years so that future generations can realise the dual goals of 'living as Māori and being citizens of the world'.<sup>28</sup>

### **TRANSFORMATIONS FOR 2014**

While the decades 1984-1994 and 1995-2004 were witness to significant changes for Māori, the directions set in train then may not necessarily be the best options for a world which will be significantly different by 2014. Transformations are time-bound so that major advances in one era may be insufficient or even inappropriate for another.

The 1984 Hui Taumata for example ushered in a decade of development taking Māori in new and positive directions. But beyond the developmental mode is a more confident mode where not only can Māori build on gains already made, but also shape the directions to suit new times and rebalance some of the imperatives that seemed so necessary in 1984.

The Ministry of Māori Development, Te Puni Kōkiri has recommended a 'Māori potential approach' as a basis for Māori policy and development. The 'potential approach' encompasses wellbeing, knowledge, influence and resources and the desired outcome is one where 'Māori succeed as Māori'. Built on the complementary pillars of rawa (wealth), mātauranga (knowledge) and whakamana (autonomy and control), the focus

is away from deficit and failure towards success and achievement.<sup>29</sup>

The potential approach requires substantial directional shifts to those that focused on greater Māori autonomy and gaining access to language, culture, and societal goods and services. While they were largely concerned with building foundations and instituting processes, the focus must now shift towards result and outcomes (table 3).<sup>30</sup>

### **Best Possible Outcomes**

In many respects Māori individuals share similar aspirations to other New Zealanders. A good outcome is one where individuals reach their potential and are well placed to compete in a global economy. However, a good outcome for Māori also reflects Māori aspirations, values and affiliations. There is no stereotypical Māori, but even allowing for diversity among Māori, it is possible to identify a number of attributes that contribute to 'being Māori'. These include:

- Identifying as Māori
- Being part of a Māori network or collective
- Participating in te ao Māori, and enjoying a closeness with the natural environment
- Using Māori language
- Possessing some knowledge of custom and heritage
- Participating as a whānau (family) member
- Having access to Māori resources

Defining best outcomes for Māori requires that 'being Māori' is adequately recognised as a determinant of wellbeing, alongside the more conventional indicators such as health status, educational achievement and economic wellbeing.

An outcome focus contrasts with a focus on procedure. During the past two decades considerable emphasis has been placed on

processes with particular stress on the incorporation of Māori values and protocols, and the creation of opportunities for active Māori involvement. While those processes have been useful, and should continue to be pursued, they should not be confused with end points. The practice of cultural safety in health services, for example, is not justified as a celebration of culture but as a means of achieving better health outcomes. Similarly, the involvement of family groups in meetings about child and youth welfare is not simply intended to fulfil a cultural preference but to ensure the best possible outcome for a child and the family. And while measures such as workforce participation can often be regarded as proxy measures for wellbeing, they do not substitute for indicators that have direct reflection on outcomes. The number of Māori adults who have no need to see a dentist because their teeth are strong and healthy, might be more relevant than the number of Māori dentists.

Because most measurements are process measures, rather than measures of outcome, it has been impossible to judge the effectiveness of a number of interventions. Part of the difficulty lies in the complexities associated with outcome measurements; there is a time lag between intervention and result; many variables apart from a specific intervention may impact on the outcome; and a good outcome for one group may be regarded as an unsatisfactory outcome by another group. But outcome measures that are relevant to Māori health, and the broader field of Māori development offer some prospect of being able to capture progress from a Māori perspective.<sup>31 32</sup>



**Table 5.3** Transformational Shifts 1984 – 2014

<b><i>1984 – 2004 Development</i></b>	<b><i>Gains</i></b>	<b><i>Limitations</i></b>	<b><i>2005 - 2014 Māori Potential</i></b>
Participation and Access	Improved levels of participation in education, health, etc.	Marginal involvement Mediocrity Uneven gains	1 High achievement, quality, excellence.
Tribal development	Tribal delivery systems; cultural integrity; commercial ventures.	Benefits not shared by all Māori.	2 Enhanced Family capacities.
Settlement of historic grievances	Major settlements completed.	Energies absorbed into exploring the past.	3 Futures orientation and longer term planning.
Protocols and processes	Māori perspectives incorporated into health, education etc.	Focus on process has diverted attention from results	4 Focus on relevant outcomes that reflect dual aims.
Government contracts	Improved service delivery. 'By Māori for Māori' Māori provider development	Dependence on state contracts; A focus on state outputs	5 Collaborative opportunities and networks; 6 Multiple revenue streams; 7 Multiple partnerships.

### **Future Orientation**

The settlement of historic grievances against the Crown, though still in progress and far from complete, has nonetheless also been a salient feature of the past two decades. Settlements were seen as necessary steps before both parties could ‘move on.’ However, the process of negotiation, coupled with a rehearsal of past events tended to reinforce an adversarial colonial relationship between Māori and the Crown. Beyond grievance there is a need to focus less on the past and more on the future.

Settlements have very often diverted Māori energies into the past, sometimes at the expense of the present and often away from considerations of the future. But the rapidly changing world with new values, new technologies and global communication, will require Māori to actively plan for the future so that generations to come will be able to participate as Māori and as global citizens.

### **Whānau (Family) Capacities**

Another transformation that occurred over the past two decades was renewed confidence in tribes to undertake functions across a broad spectrum of activities including environmental management, tribal research, the delivery of social programmes, broadcasting, and fisheries management. Tribal authorities demonstrated that in addition to reconfiguring tribal structures to meet modern needs and to operate within commercial and legal environments, they could also act as anchors for cultural revival and the transmission of customary knowledge. However, although tribal development will likely continue as an important pathway for Māori advancement, it is also likely that there will be an increasing emphasis on building family capabilities. For the most part the tools necessary for building tribal capacities are not the same tools required for developing family capacities, including the capacities for caring, for creating family wealth, for

family planning, for the intergenerational transfer of knowledge and skills, and for the wise management of family assets.

### **Quality and High Achievement**

During the Decade of Māori Development an emphasis on participation and access were important goals and there were spectacular increases in the levels of active educational participation, especially in the early childhood and tertiary years. Greatly improved rates of participation were also evident in health care, Māori language learning, business, sport, music, film and television, and information technology.

However, while access to education and other endeavours must remain important goals for Māori so that the benefits can be felt across all communities, access by itself will not be a sufficient measure of progress for 2014. Increasingly the emphasis will shift from access and participation to quality and high achievement. That will be true equally for second language learners, consumers of health services and tertiary education students. Otherwise, high participation rates might simply denote marginal involvement and mediocrity with a lack of comparability to other groups, either within New Zealand or abroad.

Pockets of brilliance and high achievement are sufficiently evident to warrant optimism but there is a need to instil the same levels of achievement across all Māori. Success should be the experience of the majority.

### **Extended Relationships and Partnerships**

For the most part providers, including some tribes, have depended almost entirely on state contracts for sustaining their business. Having contested the notion of state dependency and welfare benefits at the Hui Taumata in 1984, there would be an irony if provider development were to create further state

dependency albeit at another level. It is a reminder that multiple revenue streams embracing the private sector, combined perhaps with a system of user co-payments and global commercial ventures, might create more sustainable provider arms than total dependence on state contracts. To that end tribes and Māori as a whole will need to consider the development of a raft of relationships that include, but are not limited to, the state.

### **TOWARDS 2014: UNLEASHING MĀORI POTENTIAL**

Importantly in a global economy, relationships with other indigenous peoples and international agencies, should receive due attention. That observation is captured in the overall aim for the next decade for Māori human development that Māori should be able to 'live as Māori and be citizens of the world.'

Embedded in this aim are four key goals:

1. The participatory goal  
*full participation in education, the economy and society*
2. The indigeneity goal  
*certainty of access to Māori culture, networks, resources*
3. The goal of balanced outcomes  
*outcomes that reflect spiritual, emotional/intellectual, physical and family dimensions*
4. The anticipatory goal  
*long term planning to prepare for a changing future*

The realisation of Māori potential depends on multiple pathways and is influenced by a range of variables, some acting at a distance, others more direct some linked to national and global forces others to forces within the Māori world.

These goals are more likely to be realised if they are supported by key catalysts: effective Māori leadership, government policies that are conducive to the realisation of Māori potential, Māori

perspectives and values, a Māori workforce that is doubly qualified (cultural qualifications, educational, technical, professional qualifications), extended relationships between Māori and the state, the private sector, international agencies and other indigenous peoples.

**Table 5.4** A Framework for Considering Māori Potential 2014

<i>Catalysts for change</i>	<i>Goals</i>			
	Full participation in society & the economy	Indigeneity	Balanced outcomes	Long term planning
Māori leadership				
Conducive Government policies				
Māori perspectives and values				
A doubly qualified Māori workforce				
Extended relationships				

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<sup>2</sup> Cited in Richard Howitt, John Connell, Philip Hirsch (eds.), (1996), *Resources, Nations and Indigenous Peoples*, Oxford University Press, Melbourne, p. 10.

<sup>3</sup> Lilikala Kame'eleihiwa, (1992), *Native Land and Foreign Desires Pehea Lā E Pono Ai?* Bishop Museum Press, Honolulu, pp 23-25.

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- <sup>7</sup> J. D. Waldram, A. Herring, T. K. Young, (1995), *Aboriginal Health in Canada Historical, Cultural, and Epidemiological Perspectives*, Toronto: University of Toronto Press, 1995; pp. 55-61
- <sup>8</sup> R. Horton (2005), Indigenous Peoples: time to act now for equity and health, Comment, *Lancet*, 367:9524: 1705-07.
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- <sup>12</sup> Statistics New Zealand (2002), pp. 17-18
- <sup>13</sup> Statistics New Zealand (2002), pp. 17-18
- <sup>14</sup> Te Puni Kokiri, (1998), *Progress Towards Closing Social and Economic Gaps Between Māori and Non-Māori*, Ministry of Māori Development, Wellington, pp. 14-16
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- <sup>16</sup> Ministry of Social Development (2006), *2006 The Social Report Te Purongo Oranga Tangata*, Wellington.

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# THE TREATY OF WAITAINGI

*A Framework for Māori Health Development*

## *Te Kani Kingi*

A Key-note Address Presented at the New Zealand Association of Occupational Therapist Conference. Te Papa Tongarewa, Wellington, September 1, 2006

### INTRODUCTION

I would like to firstly extend my thanks to the organisers of this conference and for the opportunity to speak to you this morning. It is always an extreme privilege to receive these types of invitations and to play some small role in ensuring that the broad objectives of the conference are met. One of the challenges, when presenting at any type of forum, is to provide something which is both interesting and entertaining but which also offers more pragmatic insight and which contributes to the practice and activities of the participants - the everyday work they do.

In developing this morning's paper, these issues were very much at the forefront, as were the guidelines I was provided - 'to consider Māori health issues and how therapists could better engage Māori clients and the Māori community'. In considering how best to do this and to effectively reconcile and consider the multiple objectives of this presentation, I've decided to frame all

these issues within the broader context of the Treaty of Waitangi. And, to ideally construct a presentation which is informative, interesting, entertaining, and accurate - but perhaps most importantly pragmatic and useful.

## **BACKGROUND**

Using the Treaty as a framework for any type of discussion or dialogue presents many challenges and indeed opinions and ideas on the Treaty are often formed even before discussions take place. Within New Zealand, you are unlikely to find anyone who doesn't have an opinion on the Treaty or who are not prepared to espouse their views on the place of the Treaty within contemporary society. The unfortunate reality, however, is that our views on the Treaty are often informed by the media or even worse through political debate. As a consequence, our broad understanding of the Treaty and Treaty related issues are not always derived from an informed base.

However, and regardless of these concerns, there is some general consensus that the Treaty has a special significance - as the founding document of our country and as an agreement which formalised the initial relationship between Māori and the Crown. Signed on the 6<sup>th</sup> of February 1840 the Treaty was made up of five parts – a pre-amble, three articles, and a post-script (all translated from English into Māori). The Treaty of Waitangi was essentially a treaty of cessation and as such resulted in a transfer of sovereignty (or absolute control) from Māori to the British Crown.<sup>1</sup> While the Māori version of the Treaty placed some restrictions on this notion of sovereignty, the Treaty nevertheless facilitated British rule, colonisation, and the establishment of British systems of governance, land tenure, law, and social development. In effect, it legitimised Crown intervention and therefore permitted the creation of many of the Western institutions and structures we now take for granted.

Insofar as the Treaty facilitated Crown intervention, it was also, and perhaps more fundamentally, an exchange - and indeed these transfers of authority were not unconditional in that the expectations of Māori at the time were quite considerable. There is of course some debate as to whether or not Māori actually understood the Treaty and what was being negotiated. The Treaty itself was poorly translated and even less well explained. In the Māori version of the Treaty the idea of sovereignty (for example) was interpreted as governorship and meant that those that signed it anticipated crown management but also some form of Māori control. As well, there was a broader expectation, and that in exchange for Māori signatures, the interest of Māori would also be protected and in order to make good the agreement.<sup>2</sup>

The extent to which these Treaty based exchanges have been met has been the subject of some considerable debate and from the outset. The obligations agreed to by Māori (and more) have largely been met, however, there is less agreement on the extent to which the Crown has matched these – whether or not mechanisms for Māori self-governance have been made and the level to which Māori interests have been protected.

However, and putting aside the multiple interpretations of the Treaty, the position advanced within this presentation is that a fundamental intent of the Treaty was centred around a desire to promote and protect Māori health. Of course this is not typically the way in which the Treaty is described and indeed my views are not always consistent with other interpretations. However, the purpose of this presentation, is to unravel and explore the Treaty of Waitangi, its background and history, the principles and text, its interpretation and application and how this is all connected to Māori health. In this regard the broader objective is to create an understanding of the relationship between the Treaty

of Waitangi and Māori health and to likewise establish a platform through which interactions with Māori, at a personal, organisational, or community level, may be improved.

### **A TREATY IS PLANNED**

To begin with, and despite my own views this subject, there is no single opinion on what was the original intent of the Treaty of Waitangi. However, an analysis of its wording reveals that there were at least three broad objectives – first, (and as already mentioned) the cession of sovereignty, second, absolute control (by the Crown) of land matters, and lastly, law and order equally for Māori and settlers. William Hobson was responsible for drafting the Treaty, however, he was guided by a set of instructions from Lord Normanby, who in turn was influenced by various other reports on the New Zealand situation.

These reports were based on what was observed here during the early 1800s and in particular the impact unmanaged colonisation was having on the indigenous Māori population. In an 1832 report to his superiors in England, James Busby (the official New Zealand Resident) made light of the ‘miserable condition of the natives’ and which ‘promised to leave the country destitute of a single aboriginal inhabitant’. Even then, the population was in sharp decline and expectations were that this would continue and unless there was some form of active intervention.<sup>3</sup>

The type of intervention initially recommended by Busby was a ‘protectorate’ and where the Crown would administer the affairs of the country and in the interest of all inhabitants – Māori and European.<sup>4</sup> William Hobson, New Zealand’s first Governor, promoted an alternative ‘factory’ plan. This would have led to the establishment of European type settlements within certain geographical locations and within which British laws would be put in place. Māori settlements would similarly be established

and likewise see the application of Māori laws and custom within these boundaries.

Despite this, the Colonial Office in England determined that the only way to protect Māori interests (including health) was to annex the country – transferring sovereignty (absolute control) from Māori to the Crown. For this to occur, a Treaty of cessation (the Treaty of Waitangi) was required. In this regard, my main point is that while the Treaty is at times difficult to interpret there is certainly little doubt that the issue of Māori health or welfare formed much of the background to the Treaty and was significant in terms of both shaping and selling the Treaty to Māori. Indeed, and when we look at the English version of the Treaty it makes specific reference to the idea of ‘Royal Protection’ as well desire the ‘to avert the evil consequences that must result from the absence of necessary laws and institutions’.<sup>5</sup>

### **A PEOPLE IN DECLINE**

While the objectives of the Treaty were in part designed as a platform for Māori health development, based on the continued population decline, it proved to be less than successful. In fact, the 1800s was a century characterised by significant and sustained Māori de-population. Although accurate population figures were not available it was estimated that Māori numbered about 150,000 in 1800. Yet, and when an actual census was conducted in 1896, the figure was just 42,000.

The reasons for this decline and change in health profile are complex, though are not difficult to identify. The land and tribal wars during the 1800s had a particular and negative impact on the Māori population. Estimates on the number of Māori lost during tribal conflicts vary considerably – however, the most recent lowest “guestimate” is about 20,000.<sup>6</sup> Putting this figure

in perspective, it exceeds the total number of New Zealand casualties in either of the two World Wars. Certainly the introduction of the musket was a critical tool in this process and resulted in a level of devastation hitherto impossible.

The Land Wars (between Māori and Pākehā) had a similar effect as did of course the introduction of diseases that Māori had little biological protection from. Isolation from other parts of the world, allowed a unique culture to develop and flourish, but it also made Māori susceptible to many of the diseases which had ravaged other parts of the world. The population was unprepared, biologically and socially, the effects therefore were often quite devastating.<sup>7</sup>

Cultural decay had a comparable, though perhaps less obvious impact. As colonization took effect, cultural decay resulted in the abandonment of many of the social structures and practices which for hundreds of years had been used to promote and protect Māori health.<sup>8</sup> The traditional PA for example had evolved into a complex series of physical and social structures. Deliberate mechanisms were put in place and in order to ensure that fresh food and clean water was available, people were protected from the elements, waste was disposed of and in order to prevent contamination and a range of other health based practices were also adopted. However, these mechanisms were in many ways inconsistent with how the new colony was developing and in the end were abandoned as other opportunities and lifestyles were explored.

While certainly traditional ways of living would have eventually been lost, the rate at which this occurred was the real issue and especially as Māori moved directly from traditional systems to western based environments. This cultural transfer often resulted in traditional mechanisms and safeguards being abandoned. In the end it wasn't that western systems were bad for Māori, but, that

appropriate mechanisms for health and safety were displaced and not replaced.

While it is difficult to say with any certainty the extent to which each issue directly impacted on Māori health, the cumulative effect of these changes was a dramatic decline in the Māori population and with it a corresponding loss of Māori land, control, and culture.

By the end of the 1800s, and even well before, it was clear that Māori expectations of the Treaty were unlikely to be met. Insofar as providing a framework for Māori health development the offerings of the 1840 agreement had failed to materialise. Though this is perhaps not a fault of the Treaty itself, but more a reluctance by the Crown to fully implement its many provisions – including those directly connected to Māori health.

Even though, and by the beginning of the 1900s, there seemed little reason to develop any plans for Māori health – Treaty based or otherwise – when in fact many believed that the population was doomed to extinction. The only plan required was that which would manage the demise of this once noble race.

In what was to become a somewhat famous quote, Dr Isaac Featherstone summed up what was perhaps the prevailing attitude of the day;

‘The Māoris are dying out, and nothing can save them. Our plain duty, as good compassionate colonists, is to smooth down their dying pillow. Then history will have nothing to reproach us with.’<sup>9</sup>

Others held similar views and went further to suggest that the population decline was an inevitable process – consistent with Darwinian theories of natural selection and in particular the survival of the fittest.

‘Just as the Norwegian rat has displaced the Māori rat, as introduced plants have replaced native plants, so the white man will replace the Māori’<sup>10</sup>

## **RECOVERY**

Of course, the population did recover, and in dramatic fashion. And while the 1800s were characterised by depopulation, despondency, and despair, the 1900s illustrated Māori resilience and resolve, a determination which was to eventually result in one of the greatest and perhaps most un-expected recoveries in human history. Again however, the Treaty and the Crown played only a minimal role in this and in fact it was largely due to the determination of Māori and a desire to address their own health problems that a platform for Māori health development was established.

The efforts of Pomare, Buck, Ngata, Te Puia, Ratana, and organisations such as the Māori Woman’s Health and Welfare leagues require particular mention in this regard.<sup>11</sup> Indeed their role in responding to the health needs of Māori at a time of absolute crisis deserves more popular recognition. Of added interest is the fact that these health gains were often achieved in spite of limited government assistance and in the face of what must have seemed to be insurmountable odds.

## **THE ROLE OF THE TREATY**

While I have argued that the Treaty was initially (in part at least) designed as a platform for Māori health development, concerns over land confiscations and other acquisitions saw to it that the Treaty soon became an outlet for Māori frustrations. In fact, and for much of the 19<sup>th</sup>, and 20<sup>th</sup> Century the Treaty had evolved into a document which served only to highlight a series of



broken promises, particularly with respect to land, but also unmet expectations for Māori control and governance.

These concerns were complicated further by a general reluctance by the Crown to recognise the Treaty as anything other than an historical curiosity. Indeed, and in less than 40 years after its signing, Judge Prendergast notably described the Treaty as a ‘simple nullity’ – and since ‘Treaties entered into with primitive barbarians lacked legal validity’. This served as the prevailing legal position on the Treaty for nearly 100 years. It also reinforced the position of successive governments, and judges alike, and that the Treaty of Waitangi was of little importance and certainly irrelevant to legal issues.<sup>12</sup>

### **THE WAITANGI TRIBUNAL**

Over the years the legal position of the Treaty has changed, and as a result of various court cases. These decisions have often resulted in legal comment on the constitutional position of the Treaty, how each version (Māori or English) should be treated, and its relationship to legislation. These cases did much to reinforce the idea that the Treaty was primarily a tool to consider and potentially resolve historical conflicts or grievances – though were less useful in determining how the Treaty could inform contemporary and future development. For Māori also, the courts had often proved to be a fruitless and expensive exercise as debates were often limited to the English version of the Treaty and to the few instances where it actually appeared within legislation.

A significant change occurred, however, and with the establishment of the Waitangi Tribunal in 1975. Initially criticised due to the fact that it could only make non-binding recommendations, the Tribunal did at least provide a forum through which Treaty related concerns could be raised – outside

of the courts and in a way that provided greater flexibility in terms of how the Treaty could be interpreted. To this end the Waitangi Tribunal is not a court, but a commission of inquiry. While its hearings are based on a format which mirrors courtroom procedure and process (complete with judges and lawyers), unlike a court, the rulings are not binding on the Crown – they may in fact choose not to accept the tribunals findings or only partly implement what recommendations are made.

Other interesting features of the Tribunal are that only Māori can bring a claim to it, but these must be against the crown and not individuals or third parties. Despite a drive to wind-up the Tribunal and in order to settle historical treaty claims it is also important to note that most claims of this type are not actually settled through the tribunal process. In addition – settlement negotiations are not typically delayed by a reluctance by Māori to settle – but by the rigid settlement framework imposed by the Crown.

When further examining the Act under which the Tribunal was established it states that both versions of the Treaty should be regarded equally and when considering claims brought to it. Additionally, the Tribunal focuses on the “principles” or “spirit” of the Treaty as opposed to the actual text.<sup>13</sup>

The use of “principles” was designed to avoid the obvious problem of having two different versions of the Treaty, but also provided a more flexible framework for the interpretation of Treaty related concerns and obligations. Whereas in the past the Treaty (particularly within the courts) had been applied to physical resources, such as land, forest, and fisheries, the principles were broader and therefore not as restrictive. Adding to this was the opportunity to consider specific words such as Taonga and Tino Rangatiratanga as contained within the Māori version of the Treaty. It seemed, therefore, only a matter of time

before the link between Māori health and the Treaty would be established or at least re-established.

### **THE TREATY TEXT AND MĀORI HEALTH**

In considering how the Treaty may be applied to health there are (therefore) at least two broad approaches – one which is founded on the text or wording of the Treaty, and the other which is based on broader and more interpretive principles – such as those mentioned within the Treaty of Waitangi/Waitangi Tribunal Act.

By first examining the Treaty text it is clear that both versions (Māori and English) make particular references to health and which are again consistent with the various concerns that originally informed the Treaty in 1840. In the English version of the Treaty, Article 2 emphasises property rights and Article 3 stresses individual rights. There is a guarantee of ‘royal protection’ and that Māori will be afforded the same ‘Rights and Privileges of British Subjects’. As well, the pre-ambule to the Treaty further sets out the desire to ‘protect’ Māori rights and ‘to secure the enjoyment of peace and good order’. The pre-ambule also highlights the need for intervention and the fact that un-managed colonisation is unlikely to result in a positive outcome – for Māori at least.

The Māori version of the Treaty has similar objectives, although, and due to translation differences, Article 2 places added emphasis on Māori control over ‘things Māori’ and further uses the words ‘taonga katoa’ implying a connection between the Treaty and Māori social and economic development.

As noted, these statements reflected the contemporary concerns of 1840 and would have done much to encourage Māori agreement and by offering protection, certain rights, and an expectation that the outcomes for Māori would be at least as

good as that of non-Māori. However, and as shown, Māori outcomes have seldom (if ever) matched those of non-Māori – especially in health, but within a full range of socio-economic indices.

It is little wonder, therefore, that Māori have come to view the Treaty as an ideal framework for Māori health development. While some have interpreted the Treaty as affording Māori additional rights or privileges it is clear that above all else it is concerned with equity and the promise that Māori can enjoy, at the very least, the same health and well-being as non-Māori – this is clear from an examination of both the Māori and English text of the Treaty.

Confusion arises however, and when attempts are made to ensure that existing inequalities are eliminated. Some are uncomfortable with considering the Treaty in a contemporary setting even though it was never designed to sit within an 1840 vacuum. Others fail to see how it could relate to health, despite the fact that Māori health and well-being was crucial to the Treaty's design and promotion.

Official plans for Māori health have not always embraced the Treaty as an appropriate start-point or as a suitable framework from which to begin. Nevertheless, this has not prevented Māori from aligning these policies or plans with Treaty related obligations. Indeed, and regardless of whether or not targeted plans are based on need, equity, or disparities, it is clear that these are consistent with the Treaty. On the other hand, specific Treaty related plans are often framed within the notion of Māori privilege, when essentially they are about equality and balance.

In any event, my main point is that the Treaty text (both Māori and English) make clear references to Māori health and place obligations on the crown to ensure that Māori health interest are

actively protected. Further, and that while the Crown has not always employed the Treaty as an appropriate framework for health policy, this has not prevented Māori from aligning targeted approaches (in whatever context) with Treaty related obligations.

## **THE PRINCIPLES OF THE TREATY AND MĀORI HEALTH**

Despite textual references to health, debate as to the actual wording of the Treaty, and its meaning, has not always resulted in a consistent view (even amongst Māori). Some, for example, feel that the idea of Tino Rangatiratanga (as defined in the Māori version of the Treaty) is adequately met through the development of Māori specific health services and that this provides a reasonable degree of self-determination. Others are less convinced and feel that until Māori have full control of health funding and service delivery (outside of the present framework) then true Tino Rangatiratanga remains an unrealised dream.

These types of debates again highlight the variety of ways in which the Treaty may be interpreted - the meaning of certain words – in Māori and English, their historical intent and contemporary application. As noted, the Treaty of Waitangi principles were introduced in part and in order to somehow mitigate these difficulties – to arrive at a common understanding based on both versions of the Treaty and to allow it to be considered in a variety of settings.

The difficulty however, is that these principles, while frequently referred to, are mentioned nowhere within the Treaty (Māori or English) and therefore it has been difficult to say with any degree of certainty what these principles are - other than to state that they originate or are derived from the two Treaty text. Even the legislation which led to formation of the Waitangi Tribunal is

unclear about this issue and that while the Act clearly refers to the principles of the Treaty, it is silent on what these actually are.

So as to better elucidate what these principles were The Waitangi Tribunal, The New Zealand Government, the Court of Appeal, and The New Zealand Māori Council, have all developed their own set of principles and usually as a result of claims to the Waitangi Tribunal.<sup>14</sup> These principles were broadly consistent with each other and the Treaty, though were considered within the context of a particular tribunal claim. In 1988 however, the relationship between the Treaty and health was clarified and through a set of principles identified by the Royal Commission on Social Policy. And, although in 1975 the Tribunal had made way for the broader interpretation of the Treaty, it wasn't until 1988 that a set of principles, directly applicable to health and social policy, were developed.<sup>15</sup>

Like other Treaty principles, the Commission's principles of Partnership, Protection, and Participation are drawn from both versions of the Treaty and are used to better understand how the Treaty may be applied.

The principle of Partnership is derived from the original Treaty Partnership and from a health perspective places an obligation on the Crown to include Māori in the design of health legislation, policies, and strategies. It draws on the idea that Māori should play an active role in whatever plans for Māori health are devised. Further, that these relationships extend beyond central government, to local government, and how interactions with local iwi can be improved.

This principle is in part designed to address concerns that health strategies are out of sync with contemporary Māori realities and that any targeted approach should be informed by the target group. This is true for Māori health strategies, but in any

situation where disadvantage exists and where development is required. In the past Māori health issues were addressed through generic frameworks and an approach derived from the notion that cultural factors played only a minor role in the delivery of health services.

As a consequence Māori health gains were limited and it was only until cultural factors were introduced (and as part of the strategies developed by Pomare and Buck) that significant health gains were achieved. Certainly current Māori health disparities will benefit from targeted approaches – but as discussed, these must necessarily be informed by Māori and Māori realities and consistent with the principle of Partnership.

The principle of Protection is in direct reference to the Preamble, Article 2 and 3 of the Treaty. It reflects on the Crown's duty to actively protect Māori interests and to ensure that Māori are able to enjoy (at the very least) the same level of well-being as non-Māori. As noted, this principle is not designed to promote Māori privilege or to create an inequitable environment. In fact, the more fundamental objective of this principle is to eliminate inequities at all levels and to ensure that health outcomes for Māori and non-Māori are the same. In doing so two possible approaches exist. The first is to somehow slow or regress non-Māori health gains. The second, and more reasonable approach, is to lift the health status of Māori, through a range of mechanisms, and in a manner consistent with the notion of active protection.

Targeting Māori health, and in a way which leads to a reduction in disparities is another issues which has resulted in much debate about the best approach for this. Again, strategies which focus on a particular ethnic group appear to be falling out favour and are reflected in approaches which focus primarily on socio-economic factors or contributors. These ideas are based on good

science and research and are consistent with what we know about the precipitators or poor health. However, a focus on socio-economic indices alone may fail to appreciate the role of culture as a determinant of health. The fact that strategies for health promotion, public health, health protection, and even primary health care can all be enhanced through cultural means. Moreover, and while socio-economic and demographic factors are major determinants of health – they do not explain fully, why disparities exist across different ethnic groups.

The principle of Participation is linked to the principle of Partnership and Protection, but also the idea of *Tino Rangatiratanga* and the obligation to ensure that Māori are able to participate in the delivery of health services. For much of the last century, Māori participation within the health sector was largely confined to the role of consumer and even then access was not always guaranteed. Viewed from a health perspective, the principle of Participation is designed to encourage Māori involvement in the delivery of health services, but also in the planning and design of these and associated policies.<sup>16</sup> At present, access difficulties play a significant role in the perpetuation of Māori health disparities. Addressing these require a range of strategies including the development of Māori health services and giving effect to the principle of participation. In addition – it places an associated emphasis on mainstream providers and in order to ensure that at risk populations (such as Māori) have the opportunity to access the type of care they need. The fact remains that the majority Māori access the health system through conventional mainstream health service. Despite efforts to improve access (particularly by PHOs) research suggests that care pathways are uneven and that in many cases Māori do not receive the type of care they require.

As seen, these principles are not discrete or mutually exclusive and in fact none of the principles can be applied in isolation and



without considering how one affects the other. To this end the principles of Partnership, Protection, and Participation, while derived from the Treaty have a more fundamental objective and to promote and sustain positive Māori development. Indeed, and when plans for Māori health are developed, they must consider the broader issues of Māori employment, education, social and cultural well-being.

### **APPLICATION OF THE TREATY TO HEALTH**

The extent to which these principles have been applied has varied and has largely depended on the willingness of successive governments to utilise the Treaty (principles or text) within the planning process. While a consistent approach has yet to emerge, a major development occurred and with the introduction of the Public Health and Disability Act 2000. The Act was responsible for ushering in the current set of health reforms, however, and for Māori, the Act represented the first piece of social policy legislation to include references to the Treaty principles. In fact, and in so far as the Treaty is described within legislation, it is the principles, as opposed to the Treaty itself, which are used.

The inclusion of Treaty principles had a predictably negative impact on the legislation's passage through parliament and even now there is a move to have all references to Treaty principles removed from legislation. At the time the bill was being debated in parliament some were critical in that it would somehow afford Māori special privileges, though at the same time little had been made of the obvious disparities which led to its introduction in the first place. In this regard the Act (and in particular the Treaty principles) has been caught up in the unfortunate debate over political correctness and ethnic privilege, when it's more fundamental purpose (to improve Māori health outcomes and reduce disparities) seems to have been lost.

Nevertheless the Act was eventually passed, though in a somewhat watered-down version. As well, and in order to establish clear parameters for the interpretation of these principles the Act is fairly prescriptive in terms of how these principles should be interpreted. This was in part to allay the fears of some and that the Treaty would not over-ride any other sections of the legislation but to also ensure that these principles did in fact facilitate a quantifiable outcome. For example (and with respect to the principles) the Act requires a minimum Māori membership on DHB boards, and the provision for Māori membership on DHB committees. As well, it requires that board members are familiar with the Treaty of Waitangi and Māori health issues.<sup>17</sup>

Nearly six years on, and despite the initial fears of some, the principles within the Act did not push Māori to the head of the cue nor did they miraculously transform our poor health statistics. What the Act proved however, was that the Treaty did have legislative relevance to social policy and health, and that despite conflicting views on how the Treaty should be interpreted and applied it was nevertheless possible to use the Treaty and without too much conflict or compromise. In hindsight, the Act also showed that applying the Treaty did not necessarily mean that the rights of others had to be compromised or eroded.

## CONCLUSIONS

This presentation has given a brief and albeit simplistic perspective on the connections between the Treaty of Waitangi and Māori health. Of course there are other issues which potentially could inform this discussion, however, added detail does not always bring with it added enlightenment. And

certainly, an overly prescriptive and detailed discussion often results in the main issues or singular point being lost.

With this in mind, and if it is not already clear from the presentation, there are at least seven points which have hopefully been made and which may potentially improve your interactions with Māori.

The first is that the Treaty of 1840 was a contemporary response to the issues of the day and was a necessary mechanism in the face of significant and inevitable change.

The second is that Māori would not have signed the Treaty and unless they could see some benefit from it. In 1840, New Zealand was in fact made up of numerous and independent states, geographically defined by tribal boundaries, and well accustomed to negotiations, trade and debate. Māori were politically astute, a fact not missed by the Crown, and which would have influenced the overall design of the Treaty. To this end, signatures would not have been given lightly and without an expectation of something in return.

The third point is that while the Treaty was signed in 1840 it was always designed as a platform for future development. This is clear, not only from the language which was used, but also from the way in which Māori have always viewed it, and as a mechanism for contemporary development. Certainly, a number of issues have shifted its focus from the future to the past and as a consequence of numerous breaches and broken promises. Nevertheless, the opportunities presented by the Treaty still remain and may yet form a platform for mutual development and advancement.

The fourth point is that despite difficulties over the interpretation and meaning of the Treaty it has a clear and explicit relationship

to health. Whether examining the Māori or English text, the provisions or principles, the outcomes and conclusion are the same. Over time, and largely as a result of broken promises, this connection has been lost and against the backdrop of land confiscations, indigenous rights and desires for self-determination. I am certainly not suggesting that these issues are not important or that Māori well-being was the only feature of the Treaty. However, and when the multiple applications of the Treaty are explored, then the issue of Māori health must, at the very least, be considered.

The fifth point is that the Crown's approach to the Treaty (and with respect to health) is neither clear nor consistent. The health reforms of 2000 did however illustrate a willingness to at least explore, within legislation, how the Treaty could influence the shape and design of the New Zealand health infrastructure. Some, especially Māori, were initially of the opinion that it would amount to little. However, and if there is one thing that will prevent the Treaty from being included within future plans or legislation it is the idea that it will somehow negatively impact on non-Māori, create division and Māori privilege. However, and while this Act could have made a more forceful Treaty statement, the fact that the predicted social fallout did not eventuate provides clear evidence that the seamless integration of the Treaty (within legislation) is quite possible. If anything, the Act strengthens the argument for greater use of the Treaty throughout all legislation.

The sixth point, is that the Treaty may be applied in a variety of ways, at different levels, and in multiple settings. As described, the Treaty has been used to guide both health policy and health legislation. At another level it can also be used to assist health service delivery and more focused interactions between health professionals and clients. Despite confusion as to how the Treaty may be applied (especially to health) it is clear that once

all perspectives are considered it is essentially about promoting or providing the best possible outcomes. In fact, this singular objective is perhaps the easiest way to understand the Treaty, and which reflects its fundamental intent.

Of course promoting the best outcomes at an individual level is the ultimate challenge, and there is no simple way of doing so. Some useful, pragmatic, and cost effective mechanisms have however been developed and which may usefully guide clinical interactions with Māori and assist with promoting health gains. Māori signage, posters, or information booklets are fairly simple ways of adding a Māori feel to any environment and which make health services (in particular) more welcoming. And, while most patients are unlikely to be fluent (or even competent) speakers of Māori – information presented in Te Reo is likely to be of greater interest and likewise reveals a desire to at least consider Māori perspectives.

It is well considered that Māori may require more time and in order to reveal the precise nature of their health problem or in fact what their specific needs are. This may manifest in a way that means other, associated issues, are discussed first and before the more relevant concern is considered. In some cases it may also result in several consultations taking place - until an appropriate relationship has developed - and at which time the individual feels comfortable in discussing the actual issue.

Other sensitivities and behaviours may also be required. For example, immediately asking a client to reveal their name, without any preliminary remarks, could make some Māori feel apprehensive. As well, expecting Māori to engage in direct eye-to-eye contact could be interpreted as an invitation to demonstrate bad manners or as a sign of dis-respect. Alternatives to the way in which health information is provided can also be explored. Indeed, there is some evidence to suggest

that non-compliance issues are directly linked to what and how information is presented.<sup>18</sup> Again, these are but some examples of simple approaches, but which may lead to measurable improvements in assessment, planning, compliance, recovery, and health outcomes.

The fundamental task of health professionals is to promote and protect health and well-being, to assist and aid recovery and to ensure that the best possible health outcomes are achieved. This is a constant and indiscriminate objective – one which is blind to ethnicity or nationality, culture or identity, socio-economic or demographic profiles. The mistake however is when these generic objectives for health and well-being are translated into generic approaches for health service delivery, treatment, and care. Aligned with this is the flawed assumption that treating people the same will somehow translate into similar health outcomes.

The reality however, is that treating people the same is unlikely to result in similar outcomes and that ignoring cultural or ethnic factors will only serve to widen existing disparities. This is sometimes difficult to fully appreciate and indeed seems counterintuitive to the ideals of a country which has often taken pride in its non-discriminatory approach to welfare and social service delivery. However, it is perhaps time that we re-focus our lens and place greater emphasis on achieving equity from the outcomes of care as opposed to neutrality in the delivery of health services.

The seventh, and final point, is that the Treaty is not about Māori privilege or a desire to erode non-Māori rights. What it is however, is about equality and balance - an expectation by Māori of equal access to health services, appropriate outcomes, and in the design and delivery of health policies and services. These issues are of course also based on need - Māori health

inequalities, and any number of well-considered disparities. However, a needs based analysis is but one framework through which Māori health concerns can be addressed and in reality differs little from an approach derived from the Treaty. The only difference however, is that a Treaty based approach is likely to have broader Māori appeal – in part because it avoids a deficit based model, but fundamentally because it is aligned with Māori development, Māori advancement and a desire to focus on solutions rather than negative statistics. In this regard the Treaty may be considered as an appropriate framework for Māori health development.

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- <sup>4</sup> [http://www.dnzb.govt.nz/dnzb/default.asp?Find\\_Quick.asp?Person\\_Essay=1B54](http://www.dnzb.govt.nz/dnzb/default.asp?Find_Quick.asp?Person_Essay=1B54) (07/11/05)
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- <sup>8</sup> Te K. R. Kingi, (2002), *Hua Oranga: Best Health Outcomes for Māori*, Unpublished Ph.D Thesis, School of Māori Studies, Massey University, Wellington.

- <sup>9</sup> <http://www.teara.govt.nz/1966/F/FeatherstonDrIsaacEarl/FeatherstonDrIsaacEarl/en> (07/11/05)
- <sup>10</sup> <http://culturalsafety.massey.ac.nz/ChapterFive.htm> (07/11/05)
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- <sup>16</sup> Ibid.
- <sup>17</sup> T. Bennion, (2001), *Māori Law Review: A Monthly Review of Law Affecting Māori*, September Issue, Tom Bennion, Wellington.
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