Iri Ki Nga Tangaroa: In Anticipation of Better Days

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Introduction

In common with other indigenous peoples caught in the maelstrom of colonisation, the Maori of Aotearoa negotiated a Treaty with the British Crown. The relationship between the Crown and the Maori of New Zealand today is underpinned by the Treaty signed at Waitangi in 1840 and is therefore a bicultural relationship.

After a 150 year history of constant breaches by statute, deliberate action, inaction and ignorance, the Treaty of Waitangi has become a basic focus for race relations and a potential springboard from which negotiations for the cultural, social and economic future of Maori and Pakeha New Zealanders may emerge. This bicultural relationship is between the Crown in the form of the New Zealand Government, and the tangata whenua. The bicultural relationship, will extend into multiculturalism but only after the Crown and Maori have clarified theirs. All other groups of people should have their primary relationships with the first people of Aotearoa, based on the Treaty of Waitangi which guaranteed the Maori tino rangatiratanga, absolute Maori authority over those things which the Maori people define as precious.

A major taonga, or precious possession of the Maori, is our health. Maori people define health, language and birthright as precious possessions passed to us from our ancestors and which we have an obligation to maintain and preserve for the future. In 1988 the New Zealand Department of Health publicly acknowledged that the Treaty of Waitangi should be integrated into the health services. Many Maoris regard such government originated declarations with caution and suspicion, and with good reason. Health service delivery to Maori people is not good. Astonishing mortality and morbidity statistics relating to Maori are produced from New Zealand. These statistics quite clearly illustrate that all is not well with the health service.

The Maori Health Reality

Recently Maori people have been asked to contribute a 'perspective' on health matters as a way for Pakeha to make decisions about resource allocation. Many organisations have set up Maori advisory groups or single Maori advisors but the choice as to whether advice is taken or 'perspectives' are included remains with the Pakeha.

The inherent inequity of this situation has not escaped Maori people many of whom are now insisting that there is *no* Maori perspective. There is only a Maori reality. In the climate of 1989 Aotearoa it is an adjusted, post-colonial reality in which many Maoris are on a personal identity crisis continuum. The Maori reality is an experience which other New Zealanders cannot (and many do not wish to) fully share. Maori people do not challenge the validity of the reality of other cultures but are constantly challenged about theirs. Health implications are serious. Maoris are not uncommonly admitted to psychiatric institutions suffering from mate Maori (indigenous illness) and other wairua (spiritually) related conditions for which the western scientific and pharmacological repertoire has little effective treatment.

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Of fundamental importance is the acceptance of the legitimacy of differing cultural realities and the establishment of the dialectic between them. It is unhealthy to assume that there is only one reality and then to insist that everybody must conform to it. The dialectic should consist of, consultation, negotiation and a mutually acceptable outcome.

Maori women are currently dying at the highest rate on earth from carcinoma of the lung. Rates of death among the Maoris from cardiac disease, respiratory disease and carcinoma of the cervix far exceed those of the Pakeha. Post-neonatal death is 3-5 times higher than European. Maori psychiatric admission rates are currently 60% of all admissions and most of those are admitted forensically, via the police. That conjures up an interesting idea, the role of the police as diagnosticians. The incidence of Hepatitis B among Maori children is among the highest measured on earth. Porirua, a low cost, urban housing area of predominantly Polynesian population, has a higher incidence of streptoccal-induced disease, rheumatic heart disease and renal disease than Soweto in South Africa. Maori life expectancy is still almost a decade less than that of Pakeha. Similar woeful statistics in areas of Maori life extend to unemployment, housing, education, teenage suicide, and the rate of Maori imprisonment, which is second only to that of the tangata whenua of Australia, the Aboriginal people.

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What is causing these anomalies? The Maori population is comprised of 411,000 people. That represents 12.5% in a population of 3.3 million. New Zealand has been and is a relatively wealthy developed country which has had access to the resources to build a viable public health system, but the Maori have never been the focus of any particular program. What happened?

Culture

The answer lies in history and begins for the Pakeha in their year 1769 with the arrival of James Cook. The premise of Paulo Friere, the Brazilian educator, holds true in the transmission of history through systems of education in New Zealand. Friere maintains that no system of education can possibly be neutral. The division between history as the Maori records it in the oral tradition and the written history of the European in 1769 begins at contact.

The oral tradition of the Maori tells of Cook and his plague ship and the trail of disease and death by violence which followed it everywhere. The New Zealand version of that history as taught compulsorily to all children speaks of that history as taught compulsorily to all children speaks of the Pakeha 'discovery' of Aotearoa the subsequent introduction of 'civilization' and finally the rights and privileges of British subjects, to the natives. The simultaneous presence of the Frenchman, De Surville is not taught and Cook has assumed an unassailable place in New Zealand history. Aoraki, the beautiful Maori name of Aotearoa's highest mountain, has been replaced with that of the Yorkshireman who shot 'natives' in most of the places he visited.

The first people, the tangata whenua of Aotearoa are Polynesian. Migration from East Polynesia took place over several hundred years and resulted in the development of a highly sophisticated society superably adapted to the geographical and climatic conditions of their country. Like most other Polynesian cultures the Maori were and continue to be deeply integrated into the great cycles of life, earth, the spiritual realm and death. These cycles include the belief that human beings are only part of the wholeness of things and have an equal place with all the other children of the Creator. We are people who cleave to Papatuanuku, our Earth mother and seek always to live in sympathy and harmony with her. Unlike the western cultures we have not developed a worship of the sky father, but rather attempt to live in continuous communion with our earth-mother, Papatuanuku. All things animate and inanimate we regard in kinship, respecting and sharing the mauri, the life force, of everything. These relationships we regard as extremely civilized and very healthy.

Because our cyclical and spiral consciousness includes a thousand years of detailed history, our lives in the present, and a continuous concern for the coming generations, it has been a norm for our ancient people to practice a public health policy which was based on keeping people well, on health promotion. The overriding concern was that babies be born healthy and grow to healthy adulthood fit to produce more healthy babies, for they are the people of the future. It was also paramount that old people be well maintained in the community for they were and are the libraries, encyclopedias, historians and sages of the people.

Older people bring us the great gift of our history so that we may have a pattern for our future. Without these two elements the culture could not survive. A fusion of the health of young people, old people, the sea, the land and the environment created a symbiosis which formed

the basis of the primary health promotion of our ancients. They have passed these practices to us. Care of the environment included the management of agriculture and aquaculture and remains underpinned by a rich and eloquent mythology.

Colonialisation

The arrival of the Pakeha to Aotearoa brought a series of assumptions based in British theology and ideas of cultural superiority. From the late 18th century, whaling and sealing brought disease and conflict, and the introduction of the technology of war seriously altered intertribal balances. It also brought the assumption that the Maoris were interested in the cultural baggage of evangelical, religious, legal and social processes which the British brought with them. In agreeing to the treaty in 1840 our people assumed that an equal balance would be struck between the reality of the people of the land and the reality of the new settlers. What they did not anticipate was the holocaust which was to follow resulting in the deaths of over three-quarters of the population, the destruction of the beliefs and value systems which upheld the traditional culture and their replacement with alien systems which continue to fail Maori people to this day. The deprivation of our spiritual and economic base, Papatuanuku, further undermined Maori health. If the land is not well, people cannot be well, a message which is more pertinent today than ever before.

What followed was the imposition of the mechanistic, reductionist and unhealthy culture of the colonists. True to the basic western cultural tenet of reductionism the new health system was divided into sections dealing with body parts and the mind, excluding the wairua, the spirit. that was relegated to the religious specialists. Each bore little relationship to the next and all were and still are based in the philosophy that health in some way translates as disease. The environment was exploited for its mechanical and trading value and the earth became a commodity to be divided and subdivided for commercial use. Those Maoris who physically resisted this process or who aided their relatives in resistance were legislatively declared to be rebels enabling many millions of acres to be confiscated from their owners without reparation or reserves.

From the entrenched Maori position old people continued to transmit ancient knowledge, carefully protecting it and giving it only to those children who were not crushed or seduced by the new systems now called, education, law and health. Maori people began to address the crisis of mana, of spiritual dignity, confronting and examining ways to adjust the system to allow them to survive with dignity. Maoris were grievously set back by the loss of potential male leadership during the two world wars where Maori men died in disproportionately high numbers compared to Pakeha, and further set back by the high death rates among Maori women of childbearing age from tuberculosis into the 1960's. The remaining old people continued to pass on sacred and historical knowledge as a means of politicizing young people, although inevitably much as been lost.

Communication

The 1940's saw the movement of Maoris from rural areas, partly as the result of legislation incorporating communally owned Maori land which forced individuals from community occupation. Protest and angry rhetoric moved from the marae in the 1970's and was now expressed by young people in English. This articulation of anger and grief was interpreted by the descendants of the colonists as the disruption of formerly idyllic race relations. The people who spoke out were scapegoated and are still almost 20 years later described as radicals who are deliberately upsetting an otherwise satisfactory society.

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Many New Zealanders are denying and resisting the enormous social change which is inevitably occurring about them. As a result of the highly selective education system, the great majority of Pakeha in Aotearoa are aware only in the most superficial way of the Maori reality. They are trapped in the mythology of their own culture which has had to deny the true history of Aotearoa in order to establish itself here. This has resulted in the continued confident imposition of European cultural values upon those of the Maori with disastrous results in every aspect of Maori life.

Choice

There have been no health choices for Maoris since the redefinition of health and health service delivery by the colonists and its confirmation by their descendants. The Suppression of Tohunga Act of 1907 outlawed traditional practitioners in Maori health and drove their role as spiritual and physical educators underground. The cohesive social power of the Tohunga was undermined as the

Maori health structure was redefined as primitive and dangerous. (This act has recently been repealed.)

Serious ethical issues have arisen which have profound consequences for the tangata whenua. For example, the western fascination with technological refinement has meant that the New Zealand health service has underwritten eleven inordinately expensive cardiac transplants to date. Each was celebrated as a triumph of technology in a culture which values control over nature and ultimately, control over death. In the meantime disease of the ear and mastoid process in the Maori accounted for an admission rate to hospital 3 times higher than non-Maori in 1984. A survey conducted by the New Zealand Association for the Deaf in 1984, demonstrated that 85% of all Maori in prison had a significant hearing loss. All those Maori babies and children were moved through a European defined health service and education system to become 53% of the New Zealand prison population.

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Although already disproportionately high, Maori unemployment is steadily rising. Maori comprise the majority of unskilled workers prepared only for labouring occupations by the colonial education process which offers little affirmative content for Maori. In tight economic times the labour intensive smokestack industries shed workers and the communications-, electronics- and education-based industries employ those people skilled in specialist areas.

Conclusion

The projected demography for New Zealand does not bode well for the Maori. Currently the Pakeha baby boomers are moving into control of politics and policy. Several years ago the European population reached replacement. In mid 1989 the Maori also reached replacement. Between these two figures lies a large group of young Maori aged from birth to 19 years. One third of all children in New Zealand under 15 years are Maoris. The Maori population projection is youth focused but not identity focused. If these young, mostly urbanised Maori continue to come through with no choice as to how they are educated and how their health is defined and serviced, the potential for cross cultural difficulty is greatly magnified.

There will be a small increase in Maori managers and policy makers, but some basis for negotiation for change is urgently required as the Maori voice becomes stronger and people become more dissatisfied with procrastination, redefinition, rhetoric and monocultural control of powerful social institutions.

For many Maoris the answer lies in the Treaty of Waitangi. The Treaty was and still is seen by the first people as a covenant, a base document which has the mana and dignity of other profound historical documents which permeate societies such as the Magna Carta, the Old Testament or even the Hippocratic oath. The Treaty legitimates the setting up of the new settler society while confirming the rights of Maori control over Maori concerns and valuables.

In health the Treaty lays the groundwork for ideas of protection, participation and partnership between the signatories. A word of warning, however: partnerships need always to be clearly defined by both parties. As Maoris have established the demand for change in ineffective health service delivery and have articulated the need for consultation and negotiation, there has been a response from the health service. Models of negotiation have been suggested and tried almost at an individual level. There has been a slowly growing realisation that the appalling state of Maori health may not be the fault of the Maori people after all. This realisation is still relatively isolated and much of the public attitude remains based in victim blaming.

Questions are arising within the health service regarding delivery to Maori. Should the monocultural health service persist? Should there be a single health service based on ideas of bicultural delivery? Does the education of pakeha health professionals, by far the largest group of delivery agents, need to be seriously altered to include preparation to deliver appropriate service to Maori? Should the view held by many Maori that there be a separate and parallel of service delivery to Maoris be acceded to? If so, how should it be funded? To whom and how should it be accountable? Who has control? Can the Maori definition of health be regarded as legitimate? Can the Maori be trusted to furnish an effective health service by pakeha definition? What are the power relationships which have resulted in such a poor Maori health reality and how can they be adjusted?

Currently Maori initiatives to take control of our precious taonga, our health, are moving into place. Extremely active health councils and committees are well established in many Maori communities. Strategies to make existing health services more accessible are being

developed as well as alternative health choices for Maori. Programmes are being developed from a tribal basis and Maori traditional healers and health professionals are being trained in traditional skills. The growing lack of confidence in the mainstream health service is clear although the effectiveness of certain western health technologies and practices is not denied.

Maori are requiring much more control over Maori health issues particularly in the traditional areas of primary health care. Maori are requiring accountability to Maori while negotiating equal partnership status with pakeha. Maori are asking for a health service which is affordable, accessible and appropriate, all of which require considerable adjustment of the current delivery system. A Maori production house has produced a health education video designed for Maori adolescents. They had control over research, technical production, script, music and most of all the cultural idiom. A contract for this production was based on the Treaty of Waitangi and was negotiated between the Department, representing the Crown and the company. Finally Maori people are able to say that appropriate health education material has been produced to serve Maori.

For almost a hundred years the health service has been writing, in English, to an oral culture which until recently has spoken only Maori, and the health service has blamed the Maori for non-compliance. Now, the winds of change may be beginning to blow. The only limits to the creative delivery of appropriate health service to people of differing culture are the limits of the imagination and the spirit, of creative thinking. Ideas of cultural superiority are stultifying and deny the dignity and the mana to both the power culture and the oppressed. In Aotearoa the tangata whenua have been awaiting the maturation of the Pakeha, and using the treaty as a base to look forward to the negotiation of healthier days for both the peoples who agreed to the Treaty of Waitangi in the hopes of equal access to the good things which our country has to offer.

The Maoris have many good things to offer. We bring hope of reintegration of the environment with the past and the future. We believe that denial of the past, which accompanies the transplantation and growth of new cultures, enables the savage assaults upon our mother, Papatuanuku and further enables the manufacture of frightful weapons which threaten the future of our planet. These ideas are not ours and we do not wish to be part of them.

The cultures of the first peoples have much to contribute to the health of the planet and much to pass on to the children. It is with the children that the future of humanity lies and it is their lives for which we are negotiating. When the young, aggressive colonial culture can hear the voices of the ancient ones, the work can begin to restore the health of people and our mother the earth.

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References

1. de Boer Gail M and Pomare Eru W. Hauora Maori Standards of Health. A study of the years 1970-1984. *Medical Research Council Special Report Series 78. June 1988.*

2. Durie M H. The Treaty of Waitangi and Health Care. *New Zealand Medical Journal 102: 283-5. 1989.*

3. Farrell G. Pediatrician Kenepuru Hospital, Porirua. *Private conversation re-incidence of 1 Streptoccal induced disease in the Porirua area. 1986.*

4. Friere Paolo. Pedagogy of the Oppressed. *Penquin Educational Books. London 1978.*

5. Salmon G. Director General of Health, New Zealand. *Discussion on Maori psychiatric admission rates at a Health Department Hui July 1989 on Maori health.* □

" Children are powerless; they need advocates to bring their needs to the notice of the powerful. "

Unicef and SPC 'The State of Pacific Children' 1993