Does the Granting of Legal Privileges as an Indigenous People Help to Reduce Health Disparities? Evidence from New Zealand and Malaysia

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Abstract
Both the Maori of New Zealand and the Orang Asli of Malaysia are indigenous peoples who have been subjected to prejudice, discrimination and displacement in its various forms by other ethnic groups in their respective countries. However, owing to changes in the socio-political climate, they have been granted rights (including legal privileges) in more recent times. Data pertaining to the health and socio-economic status of the Maori and the Orang Asli are analysed to see if the granting of legal privileges has made any difference for the two communities. One conclusion is that legal privileges (and the granting of special status) do not appear to work well in terms of reducing health and socio-economic gaps. PHD, 2009; (15) (2); pp. 117 - 127.

Keywords: Maori, Orang Asli, indigenous peoples, health, socio-economic

Introduction
The Asian Development Bank's definition of "Indigenous People" include the following:[1]

Descent from population groups present in a given area, most often before modern states or territories were created and before modern borders were defined, and maintenance of cultural and social identities, and social, economic, cultural, and political institutions separate from mainstream or dominant societies and cultures.

Indigenous peoples of the contemporary world include the Canadian "First Nations"; Native Americans in the United States; "Indio" of Latin America; Sami of northern Scandinavia; "Pygmies" of Central Africa; !Kung of southwestern Africa; tribal minorities of China, India and Indochina, "Aborigines" of Taiwan and Australia; Maori of New Zealand, Orang Asli of Peninsular Malaysia and so on. Thus, indigenous peoples are basically the original/earlier inhabitants of a geographical region who have often been displaced by later arrivals/invaders, but who have continued to maintain a separate identity.

The Common Fate of Indigenous Peoples
In many countries, indigenous people have experienced displacement. The displacement (and social exclusion) of indigenous peoples can include any of the following:

- Geographical – being pushed to fringe or undesirable areas such as deserts, mountains and jungle
- Political – loss of political power, and being politically subordinated to other ethnic groups
- Economic – impoverishment because of loss of access to (or control over) natural resources[2]

- Social – being subjected to prejudice and discrimination, with paternalistic treatment at best, and violence and genocide at worst[3,4]
- Cultural – the culture of indigenous people are often disdained or labeled as "primitive" or "backward". The accompanying assumption is that they need to be "modernised", "civilized" and "assimilated".

This process of displacement is reflected in poorer health and socio-economic statistics:[5]

With respect to health, indigenous peoples often suffer from relatively high infant mortality rates, relatively high maternal mortality rates, lower life expectancy at birth, high cause-specific death rates for particular diseases, and show other worrisome population health indicators (high malnutrition rates, unsatisfactory growth indicators of children, high prevalence of specific diseases, high disability rates etc)

As for their socio-economic status, high percentages of the indigenous ethnic groups tend to live in poverty, experience high illiteracy rates, lower levels of educational attainment and high unemployment rates. Other indicators of social problems include greater extent of alcoholism and other types of substance abuse, more domestic violence, higher suicide rates, higher homicide rates, disproportionately high incarceration rates etc.

Recent Developments Amongst Indigenous Peoples in Various Countries

Political and social activism has made its appearance amongst formerly quiescent groups of indigenous people all over the world. Examples include: Appearance of political organizations such as the AIM (American Indian Movement) which became active in the late 1960s in USA[6] Recognition by international organisations such as the United Nations

Establishment of Nunavut as a self-governing province in Canada in 1999[7]

Native Americans – activism against use of Indian mascots in university sports and professional sports and against all forms of racist portrayals in the mass media

The continuing saga of the Zapatista Army of National Liberation in Chiapas, Mexico

Push for repatriation and reburial of remains of indigenous peoples in museum collections (usually displayed in the "Primitive Cultures" section) in Western countries such as the UK etc.[8]

Bolivia – Evo Morales (a member of the indigenous Aymara ethnic group) was elected President of Bolivia in 2005[9]

The Maori of New Zealand and the Orang Asli of Malaysia (Peninsular Malaysia)

Maori make up about 526,000 or 14.3% of the total New Zealand population.[10] The Orang Asli make up 147,412 or 0.6% of the total Malaysian population in 2003.[11] They live in Peninsular Malaysia and can be broadly divided into three main groups, i.e. the Negritos, Senoi and the Proto-Malays. In theory, both the Maori and the Orang Asli have been granted legal privileges or special status in their respective countries. The main question to be addressed in this article is "How have they been faring in recent years compared to other ethnic groups in their respective countries?"

- In the case of the New Zealand Maori, developments include:
- The setting up of the Waitangi Tribunal in 1975
- Compensation for unjust confiscation of Maori land carried out in the past
- Teaching of Maori language and culture in schools
- Maori Television established in 2004[12]
- Reserved seats for Maori politicians in the Parliament of New Zealand

As noted by one of Malaysia's experts on the Orang Asli: [13]

Article 8(1) of the Malaysian Constitution theoretically legitimises legislation "in favour" of Orang Asli by way of provisions in the law of their protection, well-being and advancement (including the reservation of land) or the reservation to aborigines of a reasonable proportion of suitable positions in the public service. (The word "protection" indicates the paternalistic mindset of the people who drafted this).

Article 45(2) provides for the appointment of Senators in the upper house of Parliament (the Dewan Negara or Senate) "capable of representing the interest of the aborigines".

Article 160(2) defines an Orang Asli as being "an aborigine of the Malay Peninsula" and the Ninth Schedule, List 1 vests upon the Federal Government legislative authority to protect their welfare.

In Malaysia, the JHEOA (Jabatan Hal-Ehwal Orang Asli or the Department of Orang Asli Affairs) is supposed to take care of their welfare. The JHEOA has the legal power to regulate their settlements, appoint and remove village heads, control entry into Orang Asli abodes, and it even has control over the crops that Orang Asli grow and the usage of their lands. Nicholas and Baer (2007) have accused the JHEOA of paternalism and cultural insensitivity.[13,14] The latter includes attempts to convert the Orang Asli to Islam and to promote their assimilation into the dominant Malay ethnic group.

The current situation of both groups (Maori and Orang Asli) may include any one of the following:
1. Stagnation or further deterioration of certain aspects of their health and socio-economic status
2. Improvement, but at a slower rate relative to other ethnic groups in their respective countries (thus resulting in a widening gap)
3. Improvement, with a narrowing of the gap between them and other ethnic groups in their respective countries

We can determines which of the three possibilities listed above apply to the New Zealand Maori and the Malaysian Orang Asli respectively by analysing data pertaining to these two groups of indigenous peoples.

Data Pertaining to the New Zealand Maori

Table 1: New Zealand Health Statistics (I): Male Life Expectancy, By Age

Age	Ethnic Group	1980 to 1984	1985 to 1989	1990 to 1995	1996 to 1999
At Birth	Maori NMNP	63.34 70.86	64.1 71.75	64.27 73.64	63.6 75.31
15 years	Maori NMNP	50.09 57.17	50.81 57.95	50.81 59.44	50.04 61.02
45 years	Maori NMNP	23.4 29.18	24.27 30.06	24.2 31.43	23.49 32.8
65 years	Maori NMNP	10.66 13.34	11.6 13.85	11.12 14.76	10.41 15.78

Source: Decades of Disparity: Ethnic Mortality Trends in New Zealand 1980-1999

New Zealand health and socio-economic data are excellent and quite comprehensive. My analysis is helped greatly by the quality of the data published in a volume called "Decades of Disparity: Ethnic Mortality Trends in New Zealand 1980-1999".[15]

From Table 1, it can be seen that life expectancy at various ages for non-Maori, non-Pacific (NMNP) males in New Zealand has been improving steadily since the early 1980s. Unfortunately, this is not the case for Maori males. There has been a reversal of the trend of steady improvement during the 1990s.

From Table 2, the same pattern is seen, i.e. life expectancy at various ages for non-Maori, non-Pacific (NMNP) females in New Zealand has been improving steadily since the early 1980s but there has been a reversal of the trend of steady improvement for Maori females during the 1990s.

Table 2: New Zealand Health Statistics (II): Female Life Expectancy, By Age

Age	Ethnic Group	1980 to 1984	1985 to 1989	1990 to 1995	1996 to 1999
At Birth	Maori NMNP	67.95 77.1	69.6 77.76	69.15 79.36	68.66 80.51
15 years	Maori NMNP	54.53 63.17	55.91 63.76	55.38 65.02	54.82 66.12
45 years	Maori NMNP	26.78 34.33	27.92 34.86	27.36 36.03	26.75 37.04
65 years	Maori NMNP	12.79 17.26	14.41 17.59	13.76 18.6	12.54 19.33

Source: Decades of Disparity: Ethnic Mortality Trends in New Zealand 1980-1999

Table 3: New Zealand Health Statistics (III): Male Age-Specific Mortality Rates, By Age Group

Age Group	Ethnic Group	1980 to 1984	1985 to 1989	1990 to 1995	1996 to 1999
1-14	Maori NMNP	64 42.1	64.2 39.3	57.4 30.1	70.8 24.7
15-24	Maori NMNP	217.3 147.1	222.7 161.6	239.9 142	231.1 110.4
25-44	Maori NMNP	371.6 164.5	379.8 160.7	356.4 150.2	378.9 138.3
45-64	Maori NMNP	2251.4 1019.9	2156.1 895.5	2063.8 742.4	2164.6 629.7
65-74	Maori NMNP	7112.9 4274.5	6623.8 3950.4	6828.5 3458.3	7165.2 2794.4

Source: Decades of Disparity: Ethnic Mortality Trends in New Zealand 1980-1999

Table 4: New Zealand Health Statistics (IV): Female Age-Specific Mortality Rates, By Age Group

Age Group	Ethnic Group	1980 to 1984	1985 to 1989	1990 to 1995	1996 to 1999
1-14	Maori NMNP	49 28.7	37.1 29.3	37.5 21.5	51.4 19.5
15-24	Maori NMNP	101.9 58.8	92.3 54.7	77.7 51.0	103.0 46.3
25-44	Maori NMNP	251.9 96.2	217.1 89.3	226.9 78.2	202.7 69.8
45-64	Maori NMNP	1573.6 575.4	1583.6 526.9	1609.5 475.1	1537.0 409.2
65-74	Maori NMNP	5327.7 2340.6	4690.4 2151.3	4730.9 1884.5	5285.7 1579.2

Source: Decades of Disparity: Ethnic Mortality Trends in New Zealand 1980-1999

From the data in Tables 3 and 4, once again, NMNP males and NMNP females show a consistent pattern of steady improvement over time. However, the pattern for Maori males and females is uneven and fluctuating, with the data from the 1996-1999 period being worse than the 1980-1984 period for many of the age-groups.

Tables 5, 6 and 7 indicate that NMNP overall health is steadily improving but this is not the case with the Maori. Once again, there has been deterioration during the 1990s.

Table 5: New Zealand Health Statistics (V): Overall Standardised Mortality Rate (SMR), All Ages

Ethnic Group	1980 to 1984	1985 to 1989	1990 to 1995	1996 to 1999
Maori	1118.7 (1.54)	903.5 (1.31)	911.2 (1.50)	1458.5 (2.87)
NMNP	724.4	688.4	607.1	508.6

Note: Ratio of Maori SMR to Non-Maori/Non-Pacific SMR in brackets
Source: Decades of Disparity: Ethnic Mortality Trends in New Zealand 1980-1999

Table 6: New Zealand Health Statistics (VI): Male SMR, All Ages

Ethnic Group	1980 to 1984	1985 to 1989	1990 to 1995	1996 to 1999
Maori	1294.7 (1.38)	1067.8 (1.22)	1071.6 (1.38)	1731.5 (2.70)
NMNP	936.2	877.3	773.9	641.2

Note: Ratio of Maori SMR to Non-Maori/Non-Pacific SMR in brackets
Source: Decades of Disparity: Ethnic Mortality Trends in New Zealand 1980-1999

Table 7: New Zealand Health Statistics (VII): Female SMR, All Ages

Ethnic Group	1980 to 1984	1985 to 1989	1990 to 1995	1996 to 1999
Maori	945.0 (1.68)	757.4 (1.40)	776.3 (1.62)	1230.6 (3.02)
NMNP	563.7	540.5	478.2	407.0

Note: Ratio of Maori SMR to Non-Maori/Non-Pacific SMR in brackets
Source: Decades of Disparity: Ethnic Mortality Trends in New Zealand 1980-1999

Table 8: New Zealand Health Statistics (VIII): Male SMR, Ages 1-74, by Cause

Cause	Ethnic Group	1980 to 1984	1985 to 1989	1990 to 1995	1996 to 1999
Cancer	Maori NMNP	222.9 137.3	221.7 133.0	236.4 129.5	262.3 116.9
CVD	Maori NMNP	447.5 241.3	406.1 204.3	400.0 159.2	398.0 116.4
Stroke	Maori NMNP	55.5 33.9	55.1 26.5	45.1 21.7	36 15.6
Motor vehicle-related injuries	Maori NMNP	58.5 27.7	58.0 30.8	53.7 24.5	46.7 18.2
Suicide	Maori NMNP	12 16.3	17.7 19.5	23.5 22.1	37.7 23.1

Source: Decades of Disparity: Ethnic Mortality Trends in New Zealand 1980-1999

When mortality is analysed for males and females by cause (Tables 8 and 9), it can be seen that mortality from cancer is a major contributor to Maori mortality. Suicide is also another important contributor (suicides have also increased amongst the NMNP population of New Zealand). Interestingly enough, for the Maori, other categories such as mortality caused by cardiovascular disease, stroke, and motor vehicle-related injuries have continued to decline although the rates remain higher than those for the NMNPs.

Table 9: New Zealand Health Statistics (IX): Female SMR, Ages 1-74, by Cause

Cause	Ethnic Group	1980 to 1984	1985 to 1989	1990 to 1995	1996 to 1999
Cancer	Maori NMNP	192.1 105.8	191.4 106.2	201.5 105.2	239.2 97.8
CVD	Maori NMNP	310.1 109.5	274.2 87.4	521.7 68.5	228.3 47.0
Stroke	Maori NMNP	68.6 27.2	52.1 20.5	48.8 16.4	41.4 12.1
Motor vehicle-related injuries	Maori NMNP	22.2 10.7	27.1 12.1	22.3 9.9	20.3 7.5
Suicide	Maori NMNP	3.8 6.1	3.4 5.7	5.8 5.5	11.8 6.6

Source: Decades of Disparity: Ethnic Mortality Trends in New Zealand 1980-1999

From Table 10, it can be seen that the Maori are worse off compared to the rest of the New Zealand population. They are less well educated, at higher risk of unemployment, have lower personal incomes and are more likely to be receiving means-tested benefits. They are also less likely to be living in their own home and more likely to be living in a household without a telephone.[16]

Table 10: New Zealand Socio-Economic Statistics, 2001 (X)

Indicator	Maori Males	Maori Females	All Maori	Other Males	Other Females	All Others
Education: High School or beyond	30.4%	34.5%	32.5%	51.7%	49.9%	50.8%
Unemployed	11.3%	11.4%	11.4%	4.2%	3.8%	4.0%
Personal Income < $10,000	27.8%	32.1%	30.1%	19.2%	28.6%	24.1%
Recieveing means-tested benefits	24.8%	36.1%	30.7%	10.2%	12.8%	11.5%
Living in household without telephone	12.2%	12.8%	12.5%	6.5%	5.7%	6.1%
Not living in own home	64.4%	65.2%	64.8%	40.3%	38.1%	39.1%

Source: Maori Health, Ministry of Health, New Zealand

Data Pertaining to the Malaysian Orang Asli[11,13, 17,18]

Table 11: Recent Malaysian Socio-Economic Statistics (I)

Indicator	Orang Asli Males	Orang Asli Females	All Orang Asli	Malaysian Males	Malaysian Females	All M'sians
Life expectancy at birth	54 years	52 years		69 years	75 years	
Households < poverty line (RM500 per month)			76.9% (80% in 1997)			6.5% (8.5% in 1997)
"Hardcore Poor"			35.2%			1.4%
Sec school dropout rate 2006			> 50%			
Literacy rate 1991			43%			86%
Households with piped water 1997			46.4%			86%

Source: Jabatan Perangkaan Malaysia and US Department of State.

Data on the Orang Asli is not comprehensive and often not up to date. Nevertheless, one can learn a lot by analysing the existing data. The data in Table 11 shows that the life expectancy at birth of Orang Asli males and females are much lower than that of Malaysian males and females overall. One can also see that Orang Asli females have a lower life expectancy than Orang Asli males – a pattern that differs from the usual one where females tend to have higher life expectancy than males.

The percentage of Orang Asli households living below the official poverty line is very high, i.e. 80% in 1997 and 76.9% in more recent years. In fact, 35.2% of the Orang Asli can be classified under the category "hardcore poor" (or the poorest of the poor).

Other indicators of poor socio-economic status include: a secondary dropout rate of more than 50% in 2006. It should be kept in mind that the numbers of Orang Asli children who enter secondary school are probably small in relation to the size of the cohort that began primary school six years earlier. The literacy rate of the Orang Asli in 1991 was only 43% and the percentage of households with piped water in 1997 was 46.4%. These are unlikely to have improved significantly in the years since.

Table 12: Health of Malaysian Orang Asli (II)
Some Findings from Research Conducted in
Orang Asli Communities

Research Study & Year Done	Key Findings
Kasim, Ismail and Ibrahim (1987)	56% of all sampled kids are underweight. 65.7% of all sampled kids are stunted
Osman & Zaleha (1995)	35% of females in sample are malnourished Goitre: 35% males 64% females
Karim et al. (1995)	Intestinal worms present: 48% of males in sample 73% of females

Table 13: Health of Malaysian Orang Asli (IV)
Some Findings from Research Conducted in
Orang Asli Communities

Research Study & Year Done	Key Findings
Zalilah & Tham (2002)	Food insecurity: 82% of households in sample Underweight: 45.3% Stunting: 51.6% Wasting: 7.8% Diet quality of children: Poor - 68.7% Fair - 31.3%
Al-Mekhlafi et al. (2005)	61.9% of sampled kids with Ascaris 98.2% with Trichurls 37% with hookworm 56.5% significantly underweight 61.3% significantly stunted 19.5% significantly wasted

Owing to the lack of comprehensive data on Orang Asli health, Tables 12 to 14 contain information that have been extracted from various published studies on the Orang Asli.[19 to 26] Each of the eight studies cited indicate that the health of the Orang Asli is poor, e.g., Kasim et. al's study published in 1987 (Table 12) found that 56% of all the Orang Asli children in their sample were underweight and 65.7% of them were stunted.

Al-Mekhlafi et. al's study on a different group of Orang Asli published almost 20 years later in 2005 (Table 14) showed that 56.5% of the kids in the sample were significantly underweight, 61.3% were significantly stunted and 19.5% were significantly wasted.

In 1995, Karim et. al (Table 12) found that intestinal worms were present in 48% of the Orang Asli males and in 73% of the females in their sample. Worm infestation findings from Norhayati et. al's study in 1997 (Table 13) are particularly bad i.e. infestation in Orang Asli kids in their study were 62.9% for Ascaris, 91.7% for Trichuris and 28.8% for hookworm. As indicated in Table 14, findings are similarly bad in Al-Mekhlafi's 2005 study (61.9%, 98.2% and 37% respectively).

Zulkifli et. al's study published in 1999 (Table 13) shows less alarming worm infestation rates, i.e. 47.5% for Ascaris, 33.9% for Trichuris and 6.2% for hookworm. But this is probably because the data deal with all Orang Asli in their study sample (kids as well as adults).

The data from Table 12 show that the health of female Orang Asli tends to be worse that that of males, e.g. much higher rates of goitre and worm infestations in females.

Conclusions

From the analyses and data presented above, the following conclusions can be drawn:

- New Zealand Maori: there has been widening of some aspects of the health and socio-economic gaps as compared to NMNP (non-Maori, non-Pacific peoples of New Zealand) because of slow improvement in some areas coupled with reversals in other areas
- Malaysian Orang Asli: there has been stagnation and possibly even further deterioration because of loss of access to land and other natural resources (as Malaysia "develops" as measured by conventional socio-economic indicators such as GNP per capita)
- The Orang Asli are marginalised to a higher degree (worse off in terms of health and socio-economic status) in Malaysia than the Maori in New Zealand
- Legal privileges (and the granting of special status) do not appear to work well in terms of reducing health and socio-economic gaps. Stronger action by the government is needed to close the gaps between the Maori and non-Maori in New Zealand and between Orang Asli and other ethnic groups in Malaysia.

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Pasifika@Massey Strategy:
Hala ki he Tau'ataina ke Ngaue'aki e 'Ulungaanga Fakafonua

Fakalakalaka Fakaako

- Fakatokolahi e fanau ako Pasifiki he ngaahi polokalama ako
- Fakapapau'I 'oku lava kakato mo lava ma'olunga 'enau ako

Ngaahi Anga Fakafonua kehekehe

- Founga fengauea'ki e 'univesiti mo e fanau Pasifiki mo 'enau ngaahi komiumiti
- Malu'I 'e he 'univesiti 'a e ngeia 'o e ngaahi anga fakafonua

Fakalakalaka e komiuniti

Fakalelei e Tu'unga Faka-ngaue

- Fakatokolahi e kau ngaue Pasifiki e univesiti
- Felave'I e ngaahi faingamalie fakangaue mo e polokalama fakaako

Fakatotolo Fakaako

- Fakatokolahi e kau Pasifiki fakatotolo lelei
- Fakatotolo 'oku fakatefito he ngaahi tui, 'efika mo e 'uluaki fiema'u 'a e kakai Pasifiki

Ngaue Fetokoni'aki

- Fengaue'aki vaofi mo e ngaahi komiuniti Pasifiki 'I NZ
- Fengaue'aki vaofi mo fe'aonga'aki mo e tukui fonua Pasifiki

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