TAMARIKI MĀORI:
A Māori view of children's rights

by
John Waldon

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1 Main Points of Working Paper

1.1 *Tamariki Māori* presents a view of the indigenous children of New Zealand from more then 20 key person interviews and original research with 150 tamariki Māori and their parents or care givers (Waldon, 2008). This report is informed by their rights as outlined in the United Nations Convention on the Rights of the Child (UNCROC) giving special consideration to article 30.[1] *Tamariki Māori* (the working paper) presents the views of tamariki Māori about wellbeing to illustrate a different view point, provides an analysis of the status of children in New Zealand, the relationship Māori have with their peers and the special place tamariki Māori hold in this country with respect to article 30.

1.2 The views of tamariki Māori suggests new approaches are required in order to better present indigenous children's perspectives.

1.3 This working paper outlines rights-related issues for the indigenous children of Aotearoa – tamariki Māori. With few exceptions tamariki Māori experience a burden of inequality (Ministry of Health, 2007) that belies their rights as children, their status as members of a priority population and subject to significant Government policy initiatives. [2]

1.4 Outlining the burden of inequity carried by tamariki Māori this working paper will assist the United Nations' Committee for The Rights of the Child (The Committee) to understand selected issues for the Government of New Zealand to address. The reform of the public sector in the 1980's, and the economy in the 1990's led to a series of changes that impacted negatively of the well-being of child and Māori health. However these reforms also saw the establishment of Māori health providers and the incorporation of Māori models of health into policy and eventually the New Zealand Health Strategy (Minister of Health, 2000). After the Child Health Strategy (CHS) was developed, determinants for child health were incorporated into the NZHS and selected determinants were assessed in terms of their impact on tamariki Māori.

1.4 The Figure *Measures to Address Article 30: an indicative assessment for Tamariki Māori* (page 7) illustrates an analysis of the state for Government support of the rights of tamariki Māori as outlined in the UNCROC Implementation Guide. Following this one page summary is an eight page supporting document that outlines the evidence supporting this summary.

1.5 The contribution Māori society (as whānau, hapū and iwi) makes to the wellbeing of tamariki Māori remains fundamental to realizing their potential if tamariki Māori are to reach their full potential as contributing adults. No social group can remain cohesive, and distinct if it is restricted by preventable and inequitable burden to nurture its children, especially when succeeding generations are exposed to the same high health risks.

1.6 The bigger issue is to ensure that tamariki Māori are not disadvantaged so that 'being Māori' is not synonymous with being sick or unfit.

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[1] **Article 30.** In those States in which ethnic, religious or linguistic minorities or persons of indigenous origin exist, a child belonging to such a minority or who is indigenous shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practise [sic] his or her own religion, or to use his or her own language.

[2] These include the Child Health Strategy (Minister of Health, 2007) and Children, Young Persons, and Their Families Act (1989) and subsequent reviews (Bazley, 1994; Brown, 2000; National Advisory Committee on Health and Disability, 1998)

2 Introduction

2.1 In order to understand the challenges to Tamariki Māori rights the sustainability and future cohesion of Māori culture and values –Te Aō Māori must be considered. The impact of inequality across generations threatens the sustainability of Te Aō Māori and can be understood by the incorporation of whānau perspectives. The new knowledge provided by whānau perspectives will aid the development of suitable strategies for addressing unfulfilled rights. While low rates of indigenous language transmission may threaten the customs and values of Māori society, the inter-generational transmission of customs, values, theology and lore, it also undermines the cultural mechanisms that establish and reinforce bonds between generations and in doing so breeches article 30 of the Convention. Te reo Māori like any living language binds together people who have values and cultural practices in common.

3 UNCROC and tamariki Māori

3.1 Nga Kaitaunaki Kohungahunga, part of the Ministry of Education's Early Childhood section, released *the Draft Charter on the Rights of a Māori Child* outlining the rights of tamariki Māori (Te Komako, 2002). While this publication was not finalised or circulated for official comment, it represented a pluralistic view of children's rights based on the Convention in English and te reo Māori. This bilingual expression of pluralism provided a new opportunity to articulate rights that included Māori institutions such as the whānau along with their cultural values and norms.

3.2 Te Komako's view was that like all children, tamariki Māori should have access to the same human rights that are the basis for freedom, justice and peace. This meant that children require special care and attention in order for them to grow up best within a loving family and whānau, and with the benefit of legal and other protection, children will flourish in an environment that acknowledges and respects their cultural values.

3.3 Judge E. T. Durie encouraged Māori, and others with an interest in the value of international conventions to look beyond literal meaning. He suggested a

> *…focus not upon the precise meanings of the words in international covenants, at least initially, but on the purpose to be achieved – to respect "the inherent dignity…of all members of the human family" as a foundation for freedom, justice and peace.*

Looking then to the spirit of the covenants rather than the terms, we may each find ways whereby particular cultural or other group preferences may be accommodated within the national legal framework, or according to the circumstances, whereby particular areas of jurisdiction can be entrusted to specialist tribunals for a specified clientele (E. T. Durie, 2000).

3.4 To this end the Convention provides that tamariki Māori, in addition to all their rights as human beings, are conferred rights as indigenous children. The importance of this has been recognised by the Committee making the rights of indigenous children the focus of the Committee's Annual Day of Discussion in 2003.

4 Measures to Address Article 30

4.1 In order to give effect to the rights indigenous children are entitled to under the Convention, the Committee noted that the Government must actively protect, sponsor and enforce in law these rights and must assist indigenous children to realise these rights ((Newell & Hodgkin, 2002) with special reference to Article 30. The Convention is available in te reo Māori, the mother tongue of many tamariki Māori, although the Government has yet to ask children if measures are appropriate or sufficient since the 34th session of the Committee.

4.2 The twelve points provide a test for the actions of governments towards children and a framework upon which progress to date can be ascertained and opportunities identified for new initiatives or the

refinement of existing polices and legislation in the light of information emerging since the most recent Government report to the Committee.

4.3 Measures taken to identify children of indigenous origin have been poor with the use of inconsistent ethnicity classification standards. As more information is gathered using uniform ethnicity classification standards ethnicity –related data is gathered, more consistency is being achieved in the official statistics contributing to better identification of children of indigenous origin. This is reflected in the health sector with the Ministry of Health adopting new ethnicity classification codes to be used in conjunction with the 2004 Ethnicity Data Protocols for the Health and Disability Sector (Protocols). These were updated on 1 July 2009 to align with the Statistics New Zealand Statistical Standard for Ethnicity 2005 (2005 Standard). Supplementary Notes to the Ethnicity Data Protocols and a revised Codeset have been published to reflect this change.

4.4 The access children have to religion and their mother tongue in New Zealand is restricted by the status of the many languages spoken in New Zealand. New Zealand has three official languages, English, Māori and New Zealand Sign Language. While the capacity and the opportunity for tamariki Māori to practice and profess their religion is not limited by Government, there appears to be no explicit support. Opportunity for the use of their own language in school, being seen, read and heard in the media is growing for tamariki Māori. Government funding is available for radio and television-based media but little is available in the print media. At school there are opportunities for many tamariki Māori to be taught in their mother tongue and in English, however the standard of education in both languages varies and relatively fewer resources are available to tamariki Māori learning in their mother tongue. The availability of Māori medium material is improving but it is fraction of that available in English therefore continuing to restrict the opportunities of tamariki Māori to learn about many aspects of their world in their mother tongue.

4.5 In legal proceedings, representation is provided for children as part of the proceeding in The Family Court, whether or not they are separated from their parents. Access to legal representation in their mother tongue is uneven and in some centres tamariki Māori may not have immediate access to legal representation competent in the child's mother tongue. The status of Māori culture under the law is less certain and subject to a claim before the Waitangi Tribunal (WAI 262) which includes the protection of Māori cultural knowledge. The rights of tamariki Māori are protected in law by the Human Rights Commission, The Race Relations Conciliator and the Childrens' Commissioner.

4.6 While the Government is supportive and endorses the Declaration of the Rights of Indigenous Peoples, it has yet to call for the meeting of countries to develop the declaration into a convention.

4.7 Sponsored campaigns to combat prejudice are the responsibility of the Human Rights Commission and the Race Relations Conciliator who are resourced by Government. The Humans Rights Commission has undertaken a programme of community development called the Diversity Action Programme. This programme brings together organisations taking practical initiatives to recognise and celebrate the cultural diversity of our society (diverse), promote the enjoyment by all participants of their civil, political, economic, social and cultural rights, regardless of race, colour, ethnicity or national origin (equal), and foster harmonious relations between diverse peoples (harmonious).

4.8 In 2008 more than 250 organisations participated in this programme. The participating organisations included tangata whenua, ethnic, cultural and religious groups, ethnic councils, and advocacy groups.

4.9 The status of the rights of tamariki Māori is illustrated in figure 1 (page 6). While most measures have had their conditions met, some still are uncertain and a few require more progress to be made. The identity and status of the language for tamariki Māori is the strongest feature of this analysis. In most cases the conditions have been met and changes have been made to address deficits in at least half

the cases. There is still opportunity to improve the situation of tamariki Māori in order to address inequalities.

5 Conclusion

5.1 The status of the rights of tamariki Māori as children who should be afforded the protection of the Convention are fragile as illustrated by relatively poor health and the low levels of educational attainment. The status of the language and culture for the communities these children belong is also fragile. With relatively fewer educational resources, lower socio-economic status, lower educational attainment, under employment and poor health in the adult community, tamariki Māori face more challenges to improve levels of attainment as measured by Government. The same data also shows that many of the families and whānau who support and nurture tamariki Māori are also in a precarious position and they are in need of the protection afforded by the right of citizenship and the equity that is highly prized in Aotearoa. While tamariki Māori are relatively disadvantaged they engage positively with many challenges they face. The solutions that have been found to address some of the inequalities faced by tamariki Māori may also assist their peers by offering a precedent for seeking new solutions. The relatively poor status of many indigenous children should not be accepted as an inevitability and being an indigenous child should not be synonymous with poverty, illiteracy, ill health and premature mortality.

Figure 1: Measures to Address Article 30: an indicative assessment for Tamariki Māori

(1) recognised the following issues regarding the rights of indigenous children, (2) whether they have made changes to address deficits and (3) capacity to right inequalities,

	1 Recognised	2 Changes Made to address deficits	3 Capacity to Right inequalities
1. Are measures taken to identify children who are of indigenous origin?	✓	✓	✓
Are measures taken to ensure that indigenous children are not denied the right to…			
1… enjoy their own culture in community with members of their group?	✓	✓	?
2… profess or practice their own religion in community with members of their own group?	✓	✓	-
3… use their own language in community with members of their group?	✓	✓	?
4…Do these measures include action taken			
a. in school?	✓	✓	-
b. in the mass media?			
c. when children are separated for any reason from their parents, family or community?	✓	✓	-
d. in legal proceedings?	✓	?	-
2..Where such children are…			
1… taught in their mother tongue as well as the majority language.	✓	✓	-
2… for whatever reason, those not fluent in their indigenous language, there are measures available for teaching them this language?	✓	✓	-
3…Are the provisions of the Convention, the Initial and Periodic Reports and all proceedings of and with the Committee on the Rights of the Child translated into all official languages?	✓	✓	?
4… protected against interference in their culture, religion and language under this article protected & enforceable in law?	✓	✓	?
5…Has the State considered the implications for law policy and practice of the Declaration on the Rights of Indigenous People?	✓	-	-
6…Are Government-sponsored campaigns initiated, where necessary, to combat prejudice against minorities or indigenous groups?	✓	-	?
7…Have tamariki Māori been asked whether the measures taken under this article are appropriate or sufficient?	?	-	-

KEY: [✓] condition met, [?] condition uncertain, [-] more progress to be made. *After Newell and Hodgson, (2002), UNICEF Iimplementation Handbook for the Convention on the Rights of the Child.*

BACKGROUND INFORMATION FOR WORKING PAPER

Māori concepts of health and wellbeing extend beyond the presence and absence of disease and include the mutual interaction of family-based relationship, spirituality and mental wellbeing (M. H. Durie, 1985; Henare, 1988; Murchie, 1984; R. T. Pere, 1997; Ratima, Edwards, Crengle, Smylie, & Anderson, 2006). How these factors are related remain especially germane to Māori understandings and it is this understanding of determinants and the inter-relationship, that can provide an explanation as to how health needs may be assessed and what health needs may present as priorities. Health determinants can be considered to act in concert and not only directly on life and well being but also be shaped by the policies of Government (Marmot, 2005). While it can be argued that this approach may be only of relevance to Māori, there are other theorists who test the relationship between the child and the social environment (Bronfenbrenner, 1986). Bronfenbrenner's social ecology of child development was developed from his own observations and an analysis of many studies of the influence of external environments on the functioning of families as contexts of child development. His contribution to understanding health determinants was to align social aggregation: family, neighbourhood, community and economy with the political environment and provide a structural approach to understanding child health (Bronfenbrenner, 1986).

Te Reo o Ngā Tamariki

The children who participated in the preparation of this report found some concepts confusing and explained that some were beyond their life experience. Where adults may take the principles as self evident and necessary, for children abstract notions regarding their well being were open to a different interpretation. These issues were tested by asking children to translate to English. The process of translation was straight forward however the results demonstrated that the child's capacity to interpret health issues in a manner similar to an adult raised two related issues, their understanding of the issue and their capacity to express the issue in their second language, English. As an example family activities and family cohesion and self esteem provided an insight into how tamariki Māori interpreted, understood and could express in English (being their second language).

Family Activities and Family Cohesion

A multi-dimensional approach that included inter generational relationships was raised as a general philosophy that fitted well with the participants. Family Cohesion (FC) brought about the most thoughtful responses from children, some of whom appeared to have considered the health consequences of the forms of behaviour described in the Family Activities scale (FA) for the first time. Adults made positive comments about the inclusion of questions that asked about the wellbeing of the child from the perspective of the family demonstrating shared values between parents and tamariki Māori.

> *I hope we [whānau] do, who else is going to worry about their health if we don't.* (FG–M (adult), Child Focus Group Interview, 03 December 2005, Kura Kaupapa Māori o Manawatū)

The notion of whānau introduced the intergenerational influence of kuia and kaumatua (elders) into the discussion. This added complexity by considering Māori perspectives of inter-generational care and the interaction of children in a wider but still family-based context. The FA questions also interrogated some concepts that were alien to this group of indigenous children. For example the situation where a child's behaviour dictated their relationship with others. This situation is foreign to the participant tamariki Māori because it challenges their values of cooperation and sharing.

The association between behaviour and the relationship with other people was a concept that was counter to the values of the schools many tamariki Māori attended in this study. The poor scoring of the translation of the questions about "wanted to be alone" and "hard to be with other" reflected the underlying value of group cohesion.

This investigation of the notions of family cohesion and family activity identified two important issues, that children assumed a high degree of collaboration within the group and family and also questioned intuitively the situation where resistance to co-operation was implied in the questions. In contrast to the children, the adults who took part in this study valued compliance with a variety of cultural norms. The challenge for children therefore was to respond to varying sets of cultural norms suggested by a generic approach to the notion of family that at times contradicted their cultural values.

Self Esteem (SE)

The concept of self esteem appealed to all the responders. Adults made most remarks about this section suggesting this was a child health issue they thought important. Self Esteem was a concept the children readily understood and could also express in English.

Although there are fourteen items in this scale and some of the translations were poorly completed the children appeared to understand the items quickly and were not confused by the complex format of the question responses. For example, children translated "how good or bad have you felt about your body and your looks?" as;

Your look and body?
The way your bodies built?
Your looks and your body?
Your body and your looks?
Your body and your looks
The look of your body?
Your looks and your body?
(BTC-1 to BTC-7)

There were fourteen items related to self esteem therefore it could be expected to be poorly completed because of the relatively large number of items. The children understood the items quickly and were not confused by the item response scale which was unique to this scale.

In conclusion the children's comprehension of philosophical issues related to well being is good and demonstrated by the high degree of translation. Children translated most of the questions they were asked (96.9%) and of interest the self esteem and family questions achieved the highest translation scores suggesting that once explained in their first language children are quite capable of bringing their own understanding to seemingly complex issues.

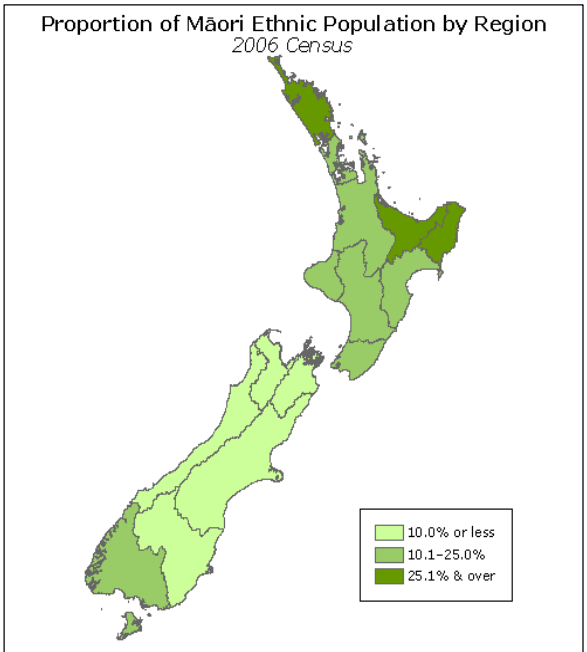

Figure 2.1 The Geographic Distribution of Māori Populations. Source: Statistics New Zealand 2007a, p. 3

Demography

The 2006 census provides the most recent demographic information for Aotearoa New Zealand (see Fig 2.1 below, Table 2.1 next page). The largest proportion of the Māori population lives in the north island of Aotearoa New Zealand (Fig 2.1). While the Māori population has grown alongside growth in Asian and Pacific peoples relative to 'European only', Māori have fallen as a proportion of the overall population by 0.5% in ten years (Statistics New Zealand, 2007b; Williamson & DeSouza, 2002).

Compared with data from the 1996 and 2001 censuses, replacement has slowed, the numbers of tamariki Māori in the 0-4 year age group falling by 1.68%. Nonetheless, Māori remain a relatively young population group contributing to 29% of the births in the 2006 calendar year (see Table 2.2).

Educational attainment for Māori over the age of 15 years has improved since the last census with an 5.77% increase in the number of Māori gaining a school or higher certificate or qualification (Williamson & DeSouza, 2002). This increase is from a relatively low base because 25% of Māori left school with no qualification in 2004 (Ministry of Education, 2007a) and educational achievement remains relatively poor.

Table 2.1 *Total Population and Births for 2006*

TOTAL POPULATION		**BIRTHS** Live births in the year ending September 2006.
Percentage of New Zealanders who identify themselves as a particular ethnic group.		**Number of births** 59,120
European	67.6%	70%
Māori	14%	**29%**
New Zealander	11.1%	
Asian	8.8%	10%
Pacific	6.6%	15%

Source: Human Rights Commission (Human Rights Commission, 2007)

Languages Spoken

English is predominant spoken in Aotearoa-New Zealand (Human Rights Commission, 2007), followed by Māori, Samoan, French, Hindi, Yue [Cantonese], (see Table 2.2, next page). For Māori in the 2006 census, 29% indicated they could hold a conversation in Māori about everyday things.

Table 2.2 Languages Spoken in New Zealand

Languages Spoken (total responses)[3] for the Māori Ethnic Group[4] (2001 & 2006 Census)		
	Census year	
Languages spoken	**2001**	**2006**
English	494,679	530,892
Māori	130,482	131,613
Samoan	4,074	3,693
NZ Sign Language	6,549	5,538
Other	9,063	9,264
None (e.g. too young to talk)[5]	17,376	15,576
Total People Stated	518,730	554,355
Not Elsewhere Included[6]	7,554	12,072
Total People	526,281	565,329
% speaking Māori	24.7%	**23.3%**

Note: This data has been randomly rounded Source: Statistics New Zealand Census 2006 (Statistics New Zealand, 2007a)

Alongside the capacity to speak their own language, there is the opportunity to participate in Māori medium education, 89% of Māori medium learners are Māori students. The Māori language is also taught outside Māori medium education to 8.3% of Māori students. In total approximately 39,852 students are being taught Māori, representing 24.5% of all Māori students (Ministry of Education, 2007b). Māori are the predominant beneficiaries of te reo Māori education and this is consistent with aspirations for the growth of Māori language and culture.

Mortality

Compared with non-Māori peers, shorter Māori life expectancy (even when adjusted for low income) (Hodgson,

[3] Includes all of the people who stated each language spoken, whether as their only language or as one of several languages. Where a person reported more than one language spoken, they have been counted in each applicable group.

[4] All figures are for the Māori ethnic group census usually resident population.

[5] Includes people who were too young to talk or unable to speak a language.

[6] Includes Don't Know, Refused to Answer, Response Unidentifiable, Response Outside Scope and Not Stated.

2007), can be expected along with fewer disability free years, more preventable illness, a poorer prognosis for cancer when it is diagnosed and poorer access to health services. This has been the case for some time (E.W. Pomare, 1980; E. W. Pomare & de Boer, 1988; E. Pomare, Keefe-Ormsby, V.,Ormsby, C.,Pearce, N., Reid, P. Robson, B., & Watene-Haydon, N., 1995).

Life expectancy for non-Māori, Māori, and Pacific boys born in 2000/02 was 77.2, 69.0 and 71.5 years respectively. Life expectancy for girls was 81.9, 73.2, and 76.7 years respectively. Length of life for non-Māori and Māori girls were 68.2 and 59 years respectively, and 65.2 and 58 years for Māori and non-Māori boys. A comprehensive review of child mortality is presented in the ACYA working paper: *Children and their Wellbeing: The Right to Health* by Pip Anderson and Kate Waterworth.

Morbidity

Māori experience high levels of morbidity in terms of hospital admission for preventable disease (Mills, Tobias, & Baker, 2002) and injury in children (Langley, 1998). A closer inspection of mortality and related morbidity for infectious disease show that Māori have relatively high rates of notification for infectious disease related to deprivation (E.W. Pomare, 1980; E. W. Pomare & de Boer, 1988; E. Pomare, Keefe-Ormsby, V.,Ormsby, C.,Pearce, N., Reid, P. Robson, B., & Watene-Haydon, N., 1995;) (with the exception of hepatitis B) and lower rates for food borne disease notification, however overall mortality for Māori remains twice that of European and Asian New Zealanders and second to Pacific Peoples as found by Anderson and Waterworth. [7]

Table 2.3 Selected Infectious disease morbidity and mortality, New Zealand

Indicator (rate per 100,000)	Males	Females	Total	Ethnic group (rate per 100,000, with standard error)			
				Māori	Pacific	Asian	European /Other
Infectious disease-related mortality, 2001–02	14.4 (13.3, 15.5)	12.0 (11.2, 12.7)	13.1 (12.4, 13.7)	**22.8** (19.1, 26.9)	**33.3** (26.3, 41.7)	12.3 (8.5, 17.2)	11.4 (10.8, 12.0)
Tuberculosis notifications, 2002–03	11.3 (10.2, 12.4)	10.4 (9.4, 11.5)	10.8 (10.0, 11.6)	17.1 (14.3, 20.3)	**45.5** (39.0, 52.7)	9.1 (8.3, 9.9)	
Meningococcal disease notifications, 2002–03	18.4 (17.0, 20.0)	15.1 (13.8, 16.5)	16.8 (15.8, 17.8)	**24.4** (21.8, 27.2)	**37.4** (32.4, 42.9)	13.1 (12.1, 14.2)	
Hepatitis B notifications, 2002–03	2.1 (1.7, 2.7)	1.4 (1.1, 1.9)	1.8 (1.5, 2.1)	**3.7** (2.6, 5.1)	**4.6** (2.7, 7.2)	1.4 (1.1, 1.7)	
Rheumatic fever (initial attack) notifications, 2002–03	3.1 (2.6, 3.8)	2.3 (1.8, 2.8)	2.7 (2.3, 3.1)	**7.1** (5.8, 8.7)	**11.2** (8.5, 14.5)	0.6 (0.4, 0.8)	
Campylobacteriosis notifications, 2002–03	404.3 (397.8, 411.0)	330.7 (324.9, 336.6)	367.0 (362.6, 371.4)	108.7 (102.4, 115.4)	63.7 (56.4, 71.7)	**496.6** (490.5, 502.8)	
Cryptosporidiosis notifications, 2002–03	27.7 (26.0, 29.6)	26.6 (24.8, 28.4)	27.2 (26.0, 28.5)	7.7 (6.3, 9.4)	2.8 (1.6, 4.6)	**40.1** (38.2, 42.0)	
Giardiasis notifications, 2002–03	46.8 (44.6, 49.1)	38.3 (36.4, 40.4)	42.6 (41.1, 44.1)	10.9 (9.1, 13.0)	4.1 (2.4, 6.5)	**59.1** (57.0, 61.3)	
Salmonellosis notifications, 2002–03	49.1 (46.8, 51.5)	42.8 (40.7, 45.0)	46.0 (44.4, 47.6)	25.4 (22.5, 28.6)	14.0 (10.6, 18.2)	**61.3** (59.1, 63.6)	

Source: Ministry of Health and Public Health Intelligence (Ministry of Health, 2007),

Table 2.4 (next page) illustrates the burden of infectious diseases that is shared by Māori and Pacific peoples. While experiencing a much lower rate of food borne disease, Māori experience much high rates of the preventable 'old world' diseases with their Pacific peers, diseases that are either vaccine preventable or associated with poverty, over crowding and poor housing. For example, the rate of hepatitis B notification is entirely reported from notified acute cases that are vaccine preventable and most probably associated with contact with the hepatitis B carrier (whose status is no longer notifiable to the Ministry of Health). The mortality associated with infectious disease demonstrates that Māori and Pacific people are exposed to greater levels of

[7] ACYA working paper: Children and their Wellbeing: The Right to Health in New Zealand - by Pip Anderson and Kate Waterworth

infection that subsequently proves fatal. Hepatitis B provides a useful case study of an infectious disease for Māori because it endemic in some Māori communities and is vaccine preventable in most cases.

Māori have reviewed the handling of this health issue (Pomare, 1985) and Māori have also been the beneficiaries of early intervention projects focused on high risk areas in order to prevent chronic infection and therefore the hepatitis B carrier state (Blakely, Salmond and Tobais, 1998).

While health inequalities remain between socio-economic classes and across ethnic groups, the compelling interaction of health burden with high dependency load will constrain effort to address unmet health needs. A focus on disease helps address medical issues but may leave little or few resources to address underlying barriers and processes that deflect effort or mitigate medical gains in knowledge and practices.

Structural Determinants of Health

> *In 1867, Māori men over the age of 21 got the vote 12 years before their non-Māori peers who had to own land in order to vote.* (Elections New Zealand, 2005)

While many factors influence health, living in safe and secure housing with safe and secure food remain powerful health determinants and subsequently benefit directly child health. The access to the resources that influence health determinants is influenced by the political process that makes the laws which regulate society (please see paragraphs 3.3, 3.4, 3.5 and 3.8, p. 11 Children and Youth Aotearoa 2010). Laws and policies that act in a differential manner on health determinants to the detriment of a population are intermediate health determinants. Intermediate health determinants may result in limited access to the cultural resources that bind cultural groups in order to sustain and protect the vulnerable. Having a 'voice' and being able to participate in policy and planning are keys to improved social and economic outcomes. Māori are now more likely to be represented in Parliament[8] and on District Health Boards[9] occupying 17.3% and 24.8% of the available seats respectively. Māori are however under represented in election positions to territorial authorities (including DHBs) (Human Rights Commission, 2007). The net effect is to have a minority voice in the making of national policy and little or no voice where the policy must be applied unless mandated by Government.

Education therefore assumes greater importance. Education is an important government mediated health determinant because its provision is largely funded by the Government in Aotearoa and has potential to contribute to structural inequalities in health for children. This view is supported by the United Nations International Children's Emergency Fund (UNICEF) in the report they commissioned to review the impact of poverty on children (UNICEF Innocenti Research Centre, 2007).

Education

Prior to 1847, Māori were taught in the Māori language at church funded Mission Schools that brought about a very high degree of literacy. The indigenous mode of communication in Aotearoa was oral and literacy was becoming more important as European migrants arrived in ever increasing numbers. Oral communication was a very important determinant and it cemented Māori society. However, the *Native Schools Act* (1852) provided a subsidy for Māori schools that taught in English and undermined Māori advances in literacy.[10] The education enjoyed by many Māori prior to the Native Schools Act paid dividends with a rapid acceleration of the economy of Aotearoa in the first two decades of the 18th century (Gardiner, 1994). Following the Native Schools Act the first two indigenous medical practitioners graduated within 50 years of the introduction of a totally new education system.

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[8] Designated Māori seats were established in 1867 and a year later the first Māori representatives were elected. Māori men who owned land were granted the franchise to vote in 1853 alongside all other male land owners; however few Māori men had title to their land, so could not register to vote until the franchise was extended to all Māori men over the age of 21 in 1867. The same right was not granted to all other non-land owning men over 21 years old until 1879. In 1892, New Zealand again led the world in the application of social justice when women won the right to vote (Elections New Zealand, 2005).

[9] 11 of the 121 DHB members elected were Māori, the Minister of Health nominated a further 39 Māori of 78 people appointed to the District Health Boards.

[10] Interrupted by the New Zealand Wars that forced the closing of schools in 1865 and the abandonment of the mission schools, the Native Schools Act was extended in 1867 with the offer to communities of a school teacher, building and resources if land was provided to site the school.

As early as 1852, the Government offered incentives to use the English language in the education system provided for all of New Zealand. But the English-only practice was flawed. After being found wanting by the Waitangi Tribunal in 1985, the Government, with constant prompting from Māori, had to redress the situation. Although slow there has been progress; 25% of tamariki Māori learning their own language at school, the highest it has been for much of the 20th century.

Table 2.5 Māori Language Proficiency in Adults 2006

Age (n=3,858) years	**Taught at Kohanga Reo** (p. 55, n=404) %	**Taught at Primary - Secondary school** (p. 55, n=656) %	**Self perceived proficiency** (p. 84, n=3,858) %				**Speaking Proficiency with Children's Teacher at Māori medium school,** (p. 49, n=869) %			
			Overall	Very satisfied-satisfied	Neither	Dissatisfied-very-dissatisfied	Overall	Very well and Well	Fairly well	Not very well / Few words
15-24	53	51	33	33	39	31	26	**28**	**21**	23
25-34	15	25	19	14	17	21	21	**20**	**22**	21
35-44	14	11	18	12	19	19	21	**18**	**20**	25
45 plus	15	11	27	34	23	26	26	**25**	**33**	19
Total	10.5	17.0		20.9	17.1	61.3	22.5	**14.1**	**13.2**	73.9

Source: (Kalafatelis, Fink-Jensen, & Johnson, 2007)

The use of te reo Māori in the school by parents appears to be low (figures in **bold**, see Table 2.5). People who have high levels of competency in te reo Māori are a minority as determined in the recent Māori language survey. Of the 3,858 people interviewed, 869 indicated they had their children educated in Māori medium education. Of those, those who could communicate well with their child's primary school teacher in Māori, almost half were under the age of 35. More than 70% of those surveyed educated in the Kohanga Reo or taught Māori at Primary school were under 35 years old. It appears that adults, who can converse fluently, are placed at an advantage but form the minority of parents who send their children to Māori medium education (see Table 2.5). While the bulk of people who speak Māori 'well' or 'fairly well' are under 35 years of age and learnt at school, relatively few are able to speak to their child's teacher in Māori medium education 'very well' (14.1%) or 'fairly well' (13.2%) in te reo Māori (Kalafatelis et al., 2007).

Unable to converse with the child's teacher reduces the capacity for the household to respond to the child's educational needs in Māori medium education. Given the recent re-emergence of Māori medium education, the minority of parents who can communicate in Māori with their child's teacher reflected the historical capacity of the education sector to teach te reo Māori in the past. This legacy now places the current generation of all school children wishing to learn Māori at a distinct disadvantage.

Fewer Māori students leave school with a qualification (30.5%) or obtain satisfactory employment (Human Rights Commission, 2007), and those that go onto tertiary education are fewer in number and are less likely to graduate (Ministry of Education, 2007a). The Government has been unable make significant gains in reducing many inequalities measured by a range of socio-economic indicators (see Table 2.6).

Table 2.6 Socio-economic indicators (age-standardised rates with standard error)

Indicator	Males	Females	Total	Ethnic group			
				Māori	Pacific	Asian	European or Other
School completion (Sixth Form Certificate or higher), 15+ years, 2001, percent	50.0 (49.7, 50.1)	50.2 (49.9, 50.3)	50.1 (49.7, 50.1)	**30.5** (30.3, 30.7)	37.8 (37.5, 38.1)	69.6 (69.2, 70.0)	52.4 (52.0, 52.5)
Unemployment, 15+ years, 2001, percent	5.5 (5.5, 5.5)	5.4 (5.3, 5.4)	5.4 (5.4, 5.5)	**10.1** (10.0, 10.2)	9.2 (9.1, 9.4)	6.7 (6.6, 6.9)	4.2 (4.1, 4.2)
Low income, 15+ years, 2001, percent	21.4 (21.2, 21.4)	30.8 (30.6, 30.9)	26.2 (26.1, 26.3)	29.3 (29.1, 29.5)	30.9 (30.6, 31.2)	**43.3** (42.9, 43.6)	24.5 (24.4, 24.6)
No access to a telephone, 15+ years, 2001, percent	7.3 (7.2, 7.3)	6.7 (6.7, 6.8)	7.0 (6.9, 7.0)	12.2 (12.1, 12.3)	**15.6** (15.4, 15.9)	4.4 (4.3, 4.5)	5.8 (5.7, 5.8)
No access to a motor vehicle, 15+ years, 2001, percent	4.9 (4.9, 5.0)	7.1 (7.1, 7.2)	6.1 (6.1, 6.1)	**12.3** (12.1, 12.4)	**12.3** (12.1, 12.5)	6.0 (5.9, 6.1)	4.7 (4.7, 4.8)
Not living in own home, 15+ years, 2001, percent	47.0 (46.7, 47.1)	45.9 (45.6, 46.0)	46.4 (46.2, 46.5)	60.3 (60.0, 60.6)	**63.2** (62.8, 63.7)	54.4 (54.1, 54.7)	43.4 (43.1, 43.5)
Household crowding, all ages, 2001, percent	9.3 (9.3, 9.4)	9.9 (9.8, 9.9)	9.6 (9.6, 9.7)	19.1 (19.0, 19.2)	**38.3** (38.0, 38.5)	18.7 (18.5, 18.9)	4.2 (4.2, 4.2)

Source: Ministry of Health, Public Health Intelligence from 2001 Census (Ministry of Health, 2007)

Intermediate Determinants

Many Māori conceive health as being the balanced interaction of social, physical, spiritual and emotional aspects of their lives (M. H. Durie, 1985; Pere, 1982) within a community with which there are reciprocal accountabilities and obligations between and across generations (McCreary & Rangihau, 1958; Rangihau, 1992; R. Walker, 1992). The rules and protocols that govern and regulate these processes have developed in parallel with changing Māori society (Mead, 2003), sometimes to the disadvantage of some Māori. Māori meanwhile have developed new resources to address changing environments (Nikora, Guerin, Rua, & Awekotuku, 2004) – a determinants approach. A determinants approach to policy formulation was recently incorporated by Government into policy (Minister of Health, 2000) and monitoring for inter-departmental consistency (Housing New Zealand Corporation, 2005). For example, some measure of over crowding may be attributed to custom and the desire to have extended family in close contact, the provision of inadequate housing or the lack of support to purchase a home reflects limited access to economic resources whether from meaningful employment or Government assistance for the low income household. Māori and Pacific carry an inequitable burden that has a demonstrable impact of health (Ministry of Health & University of Otago, 2006).

While health determinants are well understood, their inaction is less clear. The notion of intermediate determinants provides a way of describing the interaction of health determinants. For Māori intermediate determinants are characterised by those things that add to inequalities by their interaction to result in a negative health dividend. For example poor housing , over crowding (Minister of Health, 2005) and disease (Baker et al., 2000) may result in higher rates work absence to care for sick children. Too many children are, going to school hungry and school food programmes remain a feature of poorer areas of New Zealand (New Zealand Press Association, 2007). However how interventions may be applied and therefore how cultural and linguistic meaning can be accurately transmitted to improve health and wellbeing must also be considered in order to unpack health determinants like 'over crowding' that are attributed a cultural component. Language is an important determinant and cements social capital. Integrating effective interventions into existing national strategies and goals is an explicit part of health and social policy to improve the provision of resources required for maintaining health and wellbeing. An egregious example was the use of law to extinguish access to traditional medicines — the Tohunga Suppression Act of 1907 (M. H. Durie, 1998). At a time of endemic TB infection, this law was passed to make the control of the disease easier for a fledgling public health system. The Act was ineffectual in the control of an important infectious disease at a time when Māori councils appeared to be effective advocates of improved hygiene (Dow, 1999). Māori access to traditional medicines is currently limited by access to the few remaining practitioners even though the Tohunga Suppression Act was repealed in 1964.

Summary for Background Information for Working Paper

The role Māori society has in the health and wellbeing of tamariki Māori is important if tamariki Māori are to lead healthy lives as contributing adults. No social group can remain cohesive and distinct if it is unable to nurture its children, especially when the next generation is exposed to relatively high health risks while having cultural values undermined when formal education fails to support the development of tamariki Māori by failing to provide sufficient resources to sustain education in their native tongue.

Māori child health and wellbeing is characterised by the data that is summarised to a variety of health states that offer pointers as to sites of intervention. It is not enough to assess Māori child health simply in the context of the health services that are currently provided. The bigger issue is to ensure that tamariki Māori are not disadvantaged by society generally, so that 'being Māori' is not synonymous with being sick.

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Executive Summary of *Tamariki Māori*

i. *Tamariki Māori* is an ACYA working paper on the rights of indigenous children and is being sent separately.

ii. In the main, the rights of the indigenous children are respected and improvements have been made on giving effect to these rights. Inequalities and disadvantage still characterise the situation of a disproportionate number of indigenous children in New Zealand, tamariki Māori. A major hurdle was surmounted with the repeal of section 59 of the Crimes Act in 2007 (please see Paragraphs 1.51 - 1.54). Exposed to greater levels of health problems (please see Paragraphs 3.2 - 3.4 and 6.3) crime,[i] [ii] violence (see Paragraphs 5.8 – 5.17, and poverty (please see Paragraphs 6.32 – 6.52), the status of the rights of tamariki Māori show much potential for improvement.

iii. The Tamariki Māori report presents an assessment of the status of the rights of tamariki Māori as an identifiable and discrete population (please see Paragraphs 1.29 -1.34) by testing the level of support (recognition of a right, changes made to address deficits and the addressing of inequalities) by the measures taken and the situations where rights are given effect.

iv. The application of these tests to date demonstrates that the rights of tamariki Māori show improvement in the sharing of their culture with their community, practice of religion and use of their own language. While most of the improvements in these areas have happened in schools, there has been some improvement in the mass media and to some degree in legal proceedings. However more needs to be done with regard to care and protection of children separated from the parents, family and community.

v. The second stage of this assessment considers the capacity of the Government to give effect to the status of te reo Māori as a taught language, access to Convention related literature in te reo Māori, the legal protection of te reo me ona tikanga (language and culture), public anti-racism campaigns and the voice of children in assessing whether the measures taken are appropriate or sufficient. While the Government has made advances in some areas such as language revitalization, it still struggles with providing adequate recognition of rights of Māori as Indigenous people. Although New Zealand has now endorsed the Declaration on the Rights of Indigenous people (please see Paragraphs 1.12 – 1.15), the Government continues to minimise its importance.

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