



ORANGA AND
MĀORI HEALTH
INEQUITIES,
1769–1992

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Mihi

Koinei te mihi ake a te rōpū rangahau o te kerēme WAI 2575 ki ngā Manukura o te Ao Māori i tautoko mai i tēnei kaupapa. Tākuta Tā Timoti Kāretu o Ngāi Tūhoe me Ngāti Kahungunu, Tā Kevin Prime o Ngāti Hine me Ngāti Whātua, Trevor Moeke o ngā waka o Horouta, Mataatua me Takitimu, Ngahiwi Tomoana o Ngāti Kahungunu me Ngāti Hāmoa, Tākuta Rangimarie Turuki Pere o Ngāti Kahungunu, Ngāi Tūhoe me Ngāti Ruapani, Kahurangi Naida Glavish o Ngāti Whātua, Kahurangi Tariana Turia o Ngā Waiariki, Ngāti Apa, Whanganui, Ngā Rauru, Ngāti Tūwharetoa, Moe Milne o Ngāti Hine me Jean Te Huia o Ngāti Kahungunu.

Me i kore ake tā koutou hora mai i ō koutou mōhiotanga i eke ai ngā whāinga o tēnei kaupapa. E rere tonu nei ā mātau mihi mō koutou e tautoko tonu mai nei, e ārahi tonu mai nei, e arataki tonu mai nei ki tā te tohunga mahi rangatira. I taumaha hoki te kaupapa i ōna anō wā, ā, i kumea ai ko ngā tauwharewharenga o te ngākau, heoi i mauru ai nā tā koutou whakakākahu ki te korowai manaaki.

Kia tahuri ināinei ki te tini o te Māori i pēhia i roto i ngā whakatipuranga maha. I rangona tō koutou mamae, i takahia e mātau te ara i takahi ai koutou, ā, mamae ana hoki mātau. Inā kē ngā papatoiaketa o tēnei rangahau, e kī nei hoki te haka rongonui a Ngāti Kahungunu: “*He hiki aha tō hiki! He hiki roa tō hiki, i āhaha! E tama te uaua nā, e tama te mārō!*”. Heoi nā koutou, nā tātau i tutuki ai, mō tātau me ā tātau mokopuna i roto i ngā reanga ka whai mai i a tātau. E mihi ana mātau i tō koutou kaha, i tō koutou manawaroa me tā koutou piki i ēnei whakapātaritari. E poho kererū ana mātau, ā, e rangatira ana hoki i tā mātau noho hai waha mō koutou ki te whakatakoto i ngā nawe o tēnā whakatipuranga, o tēnā whakatipuranga, me te hora i tō koutou mamae nui. Ka whawhai tonu tātau kia pae rā anō te waka ki uta. Ahakoa te whenewhene o te moana, ngā piki me ngā heke, me hoe tonu tātau i te waka me kore e ū ki te pae tawhiti, ki te wawata roa, arā, ko te tauritenga o te noho a te Māori me ngā iwi katoa e noho mai nei ki Aotearoa.

Kia hoki anō tātau ki ngā kōrero a te hunga kua ngaro, kei te haka rongonui a Ngāti Kahungunu e mau ana:

“Inā hoki rā te tohe o te uaua nā, e tau nei! Ana, ana, ana, auē!”

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Preface

We have come together as a transdisciplinary team committed to a Kaupapa Māori analysis of the history of Māori health and have brought to this work our various skills, experiences and expectations along with a commitment to both share and to learn. We are not, however, alone in this task. We began by talking with esteemed Māori experts to gauge their reactions and gain their insights into our history, and our engagement with them has continued throughout our work. We are also encouraged that others have put up their hands and signalled their willingness to be involved. These rangatira are our sounding boards; our critical friends. Kia ora koutou e ngā Rangatira. Ka haere tonu tātau.

It is impossible to understand Māori health status or intervene to improve it without understanding our colonial history (Reid & Robson, 2007, p.4).

Chapter 1. Introduction

Atua
Ariki
Tupuna
Kaumātua
Matua
*Rangatira*¹

Tihei Mauri Ora! I sneeze: It is life.

Te Tapu: It is sacred

Te Mana: It is prestigious

Te Ihi: It is powerful

*Te Wehi: It is fearsome*²

The voyagers who came from East Polynesia to Aotearoa New Zealand from around the mid-thirteenth century brought with them a way of knowing, a worldview and sets of knowledge (mātauranga Māori), all valid in their own right (Hikuroa, 2017, p.5). Such traditional knowledge and culture contributed to Māori creativity, cultural practice and an understanding of everything visible and invisible in the universe, including wellbeing (Hikuroa, 2017, p.6). Māori both adapted to and reshaped their new environment, creating a cultural landscape that supported ‘oranga’³, a holistic state of wellness. By maintaining a balance between the natural, spiritual, cultural, social and political environment, Māori thrived as an indigenous people. How Māori prospered as a strong and vibrant indigenous people was (and still is) intimately tied to three culturally specific principles or determinants of oranga: whakapapa, whenua and whānau.⁴

Oranga: Whakapapa, Whenua and Whānau

Whakapapa

Whakapapa reinforces individual and collective—whānau, hapū and iwi—identity. It is also the primary organising device for iwi Māori whereby the interrelationship of all living things in te ao Māori is stored within whakapapa kōrero or creation narratives. These narratives relate the genealogical links down from Atua, deities associated with the natural environment, and the evolution of the natural world including humanity. Papatūānuku (the earth mother) provides spiritual continuity between the past, present and future, a continuity Māori maintained by returning the deceased to Papatūānuku, and by placing the whenua (placenta) of the new-born in its

¹ Hui Pakeke, Napier, June 2019.

² Whakaoranga Report, 1984, p.20.

³ Oranga is used in this report as our preferred te reo Māori term for a Māori worldview of wellness. Also see fuller explanation of the use of this term below.

⁴ Hui Pakeke, Napier, 13 June 2019.

earthly resting place soon after birth (Department of Health, 1984, p.16). Where wānanga were established where learned tohunga ensured the correct teaching of whakapapa to those of appropriate heritage and tribal standing.

Whenua—Land

All Māori social organisation was tied to the land. The way that Māori occupied and related to the land reinforced the identity of whānau, hapū and iwi and their connections and interactions with each other, whether based on kinship or on broader political purposes (Durie, 1998, p.115). Thus, the whenua provided sustenance in terms of individual and collective wellbeing and identity. One's tribal lands was one's tūrangawaewae (a place to stand), a place of belonging, the wāhi kāinga (home place) of one's ancestors. Whakapapa and whenua provided vital links between tipua, tipuna and the ongoing living world (Department of Health, 1984, pp.16–17). Tribal leadership and decisions regarding the use of whenua was vested in the authority of a rangatira (chief) whose main advisor was the tohunga, an expert in tribal lore, customs, history and spirituality. Decisions concerning the health and wellbeing of a person, however, involved the advice, support and counsel of the wider extended whānau.

Whānau

Whānau were and still are the main 'social, living and learning units in Māori society'. They exist as multi-generational groups in which the wellness of each member is dependent on their capacity to fulfil important roles of caring throughout the stages of the life cycle. As noted in the Hui Whakaoranga report,

An important function and role of parents, grandparents and the whānau, is to harness the resources and strengths of its surrounding wairua, support systems and the natural world to ensure the total growth, development and potential of the growing child, individual or whānau group (Department of Health, 1984, p.20).

Although customarily based on whakapapa, the meaning of whānau adapted overtime to accommodate the new social, economic and political environments that came with colonization. Whānau could expand beyond 'strictly kin-based definitions to those that include non-kin... and non-Māori (kaupapa-based) whānau' (Williams, 2015, p.29).

In the ways described above, whakapapa, whenua and whānau form the foundation of oranga, a holistic view of wellbeing, the stability of which was continually maintained through customary ways of engagement. The concept of 'tapu' regulated and maintained the 'harmony, balance and unity of the mind, body, soul and whānau'. Facilitating this were tikanga (customs and values), ture (laws), ritenga (customary practices), kawa (rituals), rāhui (resource management) and karakia (incantation) (Department of Health, 1984, pp. 15-19).

Tribal structures were therefore calibrated to ensure the wellbeing of future generations through the protection and conservation of land resources and an adherence to ngā tikanga Māori (aroha, manaakitanga, awhinatanga, whanaungatanga and tiaki) (Department of Health, 1984, pp. 15-19). In short, one's

well-being was also dependent on the reciprocity of giving and receiving care, assistance, compassion, for example.

Thinking about Terminology—Oranga and Wellbeing

This report does not intend to redefine Māori health or critique the terminology used to describe it. However, it does frame Māori wellbeing in a way that requires a brief discussion about Māori definitions and frameworks of health. This report adopts the term ‘oranga’ to describe a Māori worldview of wellness or wellbeing. It is not a Māori translation of health.

Māori have articulated concepts of Māori health in many forums and political contexts over the past two centuries, often as an assertion of authority over knowledge and administration of their own wellbeing. The terminology for wellbeing and/or health has also shifted over time. While acknowledging that other terms have and will continue to be used and developed to describe Māori wellbeing or the act of achieving it, like: ‘waiora’, hauora or rapuora and whakaoranga respectively, this report distinguishes between oranga and western views and measurements of ‘health’. Of course, Māori engaged with western theories and practices of health, and the chapters that follow illustrate that Māori incorporated such theories and practices into their own worldview of oranga, but the report focuses on health inequities as something distinct from oranga—part of a western system into which Māori were drawn or assimilated.

This report’s focus on whakapapa, whenua and whānau provides a framework for understanding Māori wellness consistent with many other descriptions or models of Māori wellbeing expressed over the last few decades. In fact, the introduction above and the discussion about whakapapa, whānau and whenua that follows it, draws on a Māori view of health published from proceedings of the Hui Whakaoranga in 1984 (Department of Health, 1984) and a series of hui pakeke held in 2018 and 2019. In 1984, Māori speakers detailed a holistic view of wellbeing that nurtured Māori identity, belonging to the whenua and the interconnectedness between mental, physical, whānau and spiritual wellbeing, commonly referred to today as ‘hauora’. The term hauora, however, has since been incorporated into government policy in such a way that the essence or determinants of Māori wellbeing appear to have become subsumed by other ‘health’ factors, including the measurement of inequities. The measurement of a Māori worldview of wellbeing in this report is tightly aligned with its determinants – whakapapa, whenua and whānau.

Illustrating the ongoing development of Māori health models is a set of understandings currently acknowledged by the Ministry of Health on its website (Ministry of Health, 2015a):

(1) Te Whare Tapa Whā—the four cornerstones (or sides) of Māori health framed by Professor Sir Mason Durie. This provides a holistic model of Māori health comprising the taha tinana (physical wellbeing), taha wairua (spiritual wellbeing), taha whānau (the centrality of whānau to individual and collective wellbeing), and taha hinengaro (mental health).

(2) Te Wheke is a model developed by Dr Rose Pere, based on the eight tentacles of an octopus. This concept revolves around the whānau and waiora (total wellbeing for the individual and family), with each of the eight tentacles representing a specific dimension of health, including: Wairuatanga (spirituality), Hinengaro (the mind), Taha tinana (physical wellbeing), Whanaungatanga (extended family), Mauri (life force in people and objects), Mana ake (unique identity of individuals and family), Hā a koro ma, a kui ma (breath of life from forebears), and Whatumanawa (the open and healthy expression of emotion).

(3) Te Pae Māhutonga (Southern Cross Star Constellation) which describes and brings together elements of modern health promotion. Developed by Professor Sir Mason Durie in 1999, Te Pae Māhutonga sees the task of health promotion as comprising four elements—Mauriora (cultural identity), Waiora (physical environment), Toiora (healthy lifestyles), and Te Oranga (participation in society). These elements must converge within the context of Ngā Manukura (community leadership) and Te Mana Whakahaere (autonomy) in order for modern health promotion to be properly realised.

Writing One History, Telling Two Stories: Oranga and Māori Health Inequities, 1769–1992

This report focuses on events that impacted on Māori wellbeing between 1769–1992. Although government legislation, policies and practices are a significant part of this history, it is presented from a Māori perspective to show how Māori understood, lived through and responded to events that threatened the welfare of their whānau and communities for around 250 years. In doing so, the report addresses important questions regarding how Māori defined and measured oranga and wellbeing, how Māori communities grappled with and sought solutions to events that impacted them, and why, from 1840 when Te Tiriti—the Treaty of Waitangi—was signed, ‘health inequities’ became an additional narrative in the history of Māori wellbeing. Thus, the report presents the history of Māori wellbeing as a two-fold narrative. It identifies events that affected the capacity of Māori to retain or achieve a customary measure of oranga—wellbeing—based on whakapapa, whenua and whānau, *and* it highlights events that created, or failed to stem, Māori health inequities (in its narrowest sense) to relative to non-Māori.

The Narrative of Oranga

The narrative of oranga relates how the Māori past was shaped by a holistic view of wellbeing, oranga Māori, and charts how Māori responded to challenges to it, seeking out opportunities to maintain or nurture a state of wellbeing based on the pillars of whakapapa, whenua and whānau. One could not be well if one’s whakapapa was disrupted, as it was from one’s whakapapa that knowledge about te ao Māori and self and group identity was sourced. One could not be well if one’s connection to the whenua was lost, as it was from the whenua that one’s self and group identity, belonging, and nourishment was activated and practiced. One could not be well without whānau, the most intimate social unit within which one learned about and practiced the reciprocity of caregiving, nurturing, and the giving of security.

Oranga was and still is a way of understanding and practising wellness that over the past 200 hundred years of colonization has struggled to survive in theory and practice. Indeed, a state of Māori unwell-ness, non-oranga, mate dominates this report. The narrative of oranga in the nineteenth century relates how Māori strove to maintain control of their wellbeing while the principle foundations of whakapapa, whenua and whānau were disrupted, undermined and marginalised by the state. The narrative of oranga in the twentieth century focuses on Māori attempts to find space for oranga through autonomous institutions. This is a narrative of Māori resilience and persistence⁵ in the face of tremendous pressure (Anderson et al., 2014, p.352). Māori continually strove to live in culturally enriching and empowering ways.

While tikanga and the pillars of whakapapa, whenua and whānau grounded oranga, it is important to note that oranga was and is not a static conceptual framework or a completely closed system of knowledge. It was and is a living philosophy that could adjust over time to new environments. Oranga was also open to new technologies and ideas that enhanced the wellbeing (whether life expectancy, immunity to diseases, for example) of iwi Māori.

The Narrative of Māori Health Inequality

This narrative focuses on the assimilation of Māori into a western model of health either reinforced or failed to stem unbelievably high Māori health inequities relative to Pākehā. Key areas of health inequity that the report will explore include infectious and non-communicable diseases; mental health; maternity; child mortality, and disability.

The narratives of oranga and health inequity are distinct, but not surprisingly they often intersect or converge because common to both are government policies and practices. The health system was part of a much wider system of assimilation driven by additional government policies and practices that contributed to the development of Māori-Pākehā disparities in health determinants such as housing, education and income levels. The report concurs with Cynthia Kiro's (2001, p.78) view that 'what affects the health of Māori lies more outside the gambit of the health sector than within it', and thus extends its reach beyond the impact of 'health policies' to a wide-ranging account of how land, social, and economic policies severely compromised the socio-economic environment upon which the health of Māori depended. The aim of this report is to unravel some of that complexity and to provide clarity. A summary of the health inequities Māori whānau and communities faced during the timeframes of this report is included at the end of each chapter.

The Overarching Framework—Colonization

The key impacts identified in this report are discussed within an overarching framework of colonization. The decision to overtly discuss Māori health and wellbeing within this context was not taken lightly. The term 'colonization' is sometimes used emotively and often misrepresents Māori as victims of the state, unable or unwilling to exercise agency against an invisible (and to those ignorant of the concept an

⁵ Aroha Harris uses the terms persistence, resistance and insistence as descriptors of the way Māori fought against the cultural marginalisation underpinning state policies.

imaginary) negative force. This simplistic binary belies a much more complex dynamic. Historian Judith Binney (2010, p.96) describes how the reality of ‘the autonomy of the Māori world’ reveals itself after the layers of ‘the state, its agents and its institutions’ have been peeled back. Māori at times embraced or rejected capitalist, religious, political and technological concepts and tools as a means of enhancing or protecting the oranga of their tribalscapes. Indeed, colonization brought times of economic prosperity, opportunity and growth for Māori. However, such benefits, this report argues, were short-lived and outweighed by the severe and persistent negative impacts on oranga.

The report’s framework challenges the view that colonization is something that ended in the nineteenth century. It will show that colonization was underpinned by assimilative policies and practices that began in the nineteenth century and continued into the twentieth century as a ‘historic process predicated on assumptions of racial, religious, cultural and technological superiority’ (Walker, 1990, p.9). The history of oranga and health inequity are embedded within this ongoing narrative of colonization, from the 19th century destruction of tribal economies via war and land alienation, to the underfunding of autonomous Māori health initiatives in the early 20th century, to determining when and how Māori could shape and deliver so-called ‘bi-cultural’ health policies in the late twentieth century. The way in which colonization impacts on oranga and ‘Māori health’ is persistent and multifaceted, operating at personal, whānau, local and national levels.

Much recent literature supports the argument that colonization or particular aspects of it had a detrimental impact on the wellbeing of Māori people and communities (Mikaere, 2011, pp.232–233, Pihama et al., 2014, p.248, Gabel, 2019, pp.3, 4 & 18). Māori land alienation and the New Zealand wars are two of the most obvious historical ‘events’ cited. Historian James Belich is clear that although Māori did not die out as some nineteenth-century commentators predicted, the New Zealand wars left Māori with reduced capacity to ‘control social and cultural assimilation, the application of coercive British law, and the alienation of land’ (Belich, 2015, pp.300, 305). Ani Mikaere provides a summary of the events and processes that she assigns to colonization:

These developments [colonization] were reinforced by the destruction of the whānau network, a result of widespread land theft and social upheaval brought about by introduced diseases and the urban migration which occurred during the middle of the twentieth century (Mikaere, 2011, pp.232–233).

How urban migration factors into oranga is arguably more complicated than it being a negative contributor and/or outcome of colonizing events. Urbanization did not happen to Māori, but Māori did move to protect oranga within an assimilative environment that necessitated creating cultural enclaves in the cities. Although successful, the ongoing transfer of knowledge could not compete with the socio-economic pressures facing an increasingly marginalised population in the cities. Even Māori in rural areas were struggling to survive.

Colonization, Trauma and Whakamā

The Ngāi Tahu Research Centre's recent report into 'the trauma caused by settler colonization on Ngāi Tahu whānau' illustrates that colonization is more than a chronology of interrelated events. It describes a 'colonising environment' as an 'atmosphere created by settler states that traumatises through economic and political instability, arbitrary justice, and constant threat' (Reid, Rout, Tau & Smith, 2017, p.9). They 'demonstrate that the colonial environment shifts over time, steadily undermining the independent social and economic structures of whānau and hapū which directly results in poor physical, psychological, and social health' (Reid et al., 2017, p.9).

This report also supports the view of Pihama and colleagues (2014) who argue that,

...in order to engage fully with the impacts of colonization on Māori wellbeing we must articulate fully the impact of historical trauma events and the contribution of those events to negative health disparities experienced by many of our whānau, hapū and iwi (p.248).

This argument also entails an exploration of the ongoing process of colonization in that,

...the trauma of colonization is not simply something that happened in the past, the ramifications of which are passed down to affect current generations, but also a reality still experienced by many Māori as both politico-economic deprivation and cultural alienation from the settler state and wider society (Reid et al., 2017, p.10).

In analysing the impacts of such an historical environment on oranga, the report points to whakamā as one important intergenerational outcome of being exposed to culturally and economically oppressive living environments. Whakamā, as illustrated in chapters three and six, is presented as a cultural response to the ongoing pressures of colonization. It includes holding and responding to 'feelings of injustice, powerlessness and frustration' (Buchanan, 2012, pp.66-67). That sense of injustice, powerlessness and disadvantage was a reality that impacted and continues to impact on oranga to this day.

The Historiography

This report presents an oranga-centric history of Māori, from 1769 to 1992. The pillars of oranga—whakapapa, whenua and whānau—necessitate a broad representation of the Māori past. The importance of the whenua to oranga Māori, in particular, takes this history into areas of New Zealand's past seldom viewed as connected to 'Māori health': the New Zealand wars, land courts and land development schemes are just a few examples. Much of what is presented will be familiar to readers with a good general knowledge of Māori and New Zealand history.

The report draws almost entirely on secondary literature. The history, *Tangata Whenua: An Illustrated History*, proved an invaluable resource. The work is very recent (2014) and draws on a huge volume of literature that would have been a challenge to access and assess in the preparation of this report. It is also a multi-authored work, written by respected experts in their respective fields of New Zealand and Māori history. The framing and findings of this report, however, should not be viewed as a reflection of

Tangata Whenua or the views of its authors. In the mix are other works and authors, including Vincent O'Malley, Aroha Harris, Ranginui Walker, Melissa Matutina Williams and social historian Margaret McClure. Richard Hill's (2004) work on the Māori quest for autonomy also shapes this history's analysis of the power dynamic underpinning the narratives of oranga and health inequities. Hill argues that the state is a dispassionate institution, geared to maintaining political stability. At times this meant providing Māori with limited and often short-term autonomy. Even though individuals within the government body may have held humanitarian values or expressed good will in their actions and words, the machinery of the state and colonization was inflexible to real and meaningful power sharing. The overriding goal of the state was to effect the gradual assimilation of Māori into the social, political and economic frame of western living. This pattern of assimilation and limited autonomy plays itself out in this history of oranga and health inequities.

Māori Health Historiography

The decision to conduct a dual-analysis (oranga *and* Māori health inequities) required that we address an additional set of literature that could provide details of people, practices and statistics of Māori health. Derek Dow's work on Māori health policy provided two overviews of Māori health policy: 1840–1940 and 1940–2000. These works usefully mapped out the development of health policies and legislation over the course of the period of this report. However, Dow's interpretation of the intent and outcomes of government health legislation and policy is quite narrow. Māori health policy was inextricably tied to a broader frame of Native/Māori policy. Also, a Māori view of wellbeing is seldom accounted for in his work. Additional literature includes Raeburn Lange's history of Māori health development: 1900–1920, and Linda Bryder's research into tuberculosis and infant welfare. Bryder's work is well researched and detailed and helpfully explores the intersection of health and race in New Zealand. Other useful works included the *Hauora: Māori standards of health* series by Eru Pōmare and his colleagues, D. E Hanham's thesis on introduced diseases: 1790–1840, Ian Pool's work on Māori demography, Alison Day's analysis of the 1913 smallpox epidemic, and many academic treasures found mostly in the *Journal of the Polynesian Society*.

Straddling both sets of historiography are Professor Sir Mason Durie's books and papers on Māori health. He is a lone author in this regard, which is both a testament to his commitment to a Māori worldview of wellbeing and his life work in the field. In many ways this report reinforces Durie's argument that the wellbeing of Māori people cannot be best or solely measured against that of Pākehā. In 1999 Lange recognised connections between the goals, priorities and strategies espoused by Durie and Māori working to improve oranga in the early nineteenth century, namely that Māori wellbeing is about Māori self-determination (Lange, 1999, p.ix). That very little had changed in over 100 years is concerning to say the least.

Although this report reflects some of the key issues, events and Māori understandings raised by Durie and many of the other authors above, it stands alone in its argument and final representation of a history of the events that impacted oranga and created Māori health inequities in the time period of 1840–1992.

The Question of ‘Balanced’ History

In writing the events that impacted on oranga, a very broad analysis of Māori history is provided. However, it is not a ‘history of Māori’. It is oranga-centric and, so, some people, organisations, events and diversities (tribal, gendered) of the Māori past have not been discussed in detail or at all. Also, in balancing Māori agency with the colonising forces Māori fought against, some of the more positive aspects of community life—arguably the stuff that made life worth living (sports, weddings, the arts and so on)—have been sacrificed to illustrate the dire circumstances in which they occurred.

Conversely, and somewhat emphasising the omission of such positive community events, is this report’s detailed examination of the events that undermined oranga and/or contributed to Māori health inequities. The New Zealand wars, where they occurred and their short- and long-term impacts are discussed in relatively high detail, as is the work and strategies of Māori parliamentarians at the turn of the twentieth century. This focus is to ensure that the breadth and depth of the grinding forces of colonization on oranga are relayed in a way that illustrates the weight of such pressures on Māori communities.

Writing Oranga—A Word From the Research Team

The production of this report was undertaken by a group of Māori researchers who work in diverse fields and thus draw on diverse knowledge and experience, from midwifery practice and health management, to health and historical research and writing. The importance of this history has weighed heavily on our collective shoulders. Although this report presents a history of loss and trauma, it also presents a history of Māori resilience. We hope this history offers a way forward. The report illustrates that ‘big picture’ solutions will be required to undo more than two-centuries worth of damage to the oranga of iwi Māori.

We the writers, like all Māori, balance the day-to-day challenges that come with past land loss, poverty, cultural marginalisation, addictions, mental health issues and non-communicable diseases – cancer, in particular. We are not disconnected from this history but have sought, nevertheless, to provide a balanced account of oranga and Māori health inequities. As mentioned, this report is not about redefining or critiquing Māori health models. The following section of this chapter begins laying out the dynamics of oranga in its historical context to provide a means by which we can measure the impacts of colonization on it as the report progresses through time.

The Dynamics of Oranga, pre 1769

Oranga must have been central to the socio-cultural organisation of Māori who arrived in Aotearoa in the thirteenth century. From an initial migrant population of 100–200 people that arrived between 1230–1280AD (Anderson et al., 2014, p.35), the population by the late eighteenth century was around 80,000 to 150,000, ‘with 90,000 to 100,000 the preferred estimate (Anderson et al., 2014, p.123). Not much is known about that population growth. Lange (1999, p.7) cites demographer Ian Pool’s suggestion that population growth was because the birth rate exceeded the death rate with a natural annual Māori population increase of around half a percent (Pool, 1991,

pp.35,37,41,57). But Māori also developed other ways in which to protect and promote life. Mason Durie argues that by the 18th century Māori had established a ‘public health’ system that regulated daily life and the kaitiakitanga or care and careful use of key natural resources, especially the whenua and water sources (Durie, 1994, pp.8–25).

Maintaining oranga demanded a physically intense lifestyle that supported a strong physique but also predisposed Māori to certain diseases. Archaeological evidence shows that early Māori were strong, healthy and tall, but that some non-communicable diseases existed. The Wairau Bar is one of the most significant early sites of Māori occupation with studies showing that Māori men had an average height of 5 foot 9 inches (175 centimetres) and 5 foot 3 inches (160 centimetres) for Māori women. Relative to European averages, Māori were ‘long-bodied’ though ‘wide-shouldered, broad-hipped and strongly built’. The co-existence of ‘heavy musculature’ with high instances of degenerative disease—osteoarthritis especially—denotes a labour-intensive society whose activities included fishing, fowling, tilling, making nets, structures and tools for men; and shell-fishing, collecting fern-root, cooking and weaving for women (Anderson et al., 2014, pp.38, 140). A gritty and fibrous diet meant that teeth could easily become worn such that dental disease was common and, for some, lethal (Anderson et al., 2014, p.38). Further archaeological evidence, along with a small sample of early European accounts, indicates that Māori were not exempt from non-communicable diseases such as cancer, gout, kidney and heart disease (Hanham, 2003, p.32). Philip Houghton, an expert in skeletal archaeology in New Zealand, presents a case of cancer located at the Wairau Bar, whereby the woman’s cranium had erosions inside the skull suggesting a secondary cancer or histiocytosis X (Hanham, 2004, p.33; Houghton, 1980, p.144).

Life expectancy was thought to be on a par with European rates of around 30–35 years. Although accounts of Māori longevity in the late 18th century cannot be substantiated by archaeological evidence, Hanham (2003, p.42) asserts ‘... there are sufficient eye witnesses...to accept that there were a number of old people, aged perhaps between 60 and 70 years of age’ during that period. Longevity is also confirmed by the post-contact memories of older Māori who could remember events (e.g., Cook’s visit) that offered proof of their longevity (Hanham, 2003, p.43).

Tohunga and Rongoā

Sickness and a state of poor health could manifest in a wide range of ways and extended beyond the physical and mental to an imbalance between one’s whānau, tribal grouping and the wider environment. Māori beliefs surrounding matenga or sickness were tied to the spiritual world and were seen as ‘the result of a temporary disharmony with nature and society’ (Lange, 1999, p.8); a disruption to moral and spiritual wholeness, caused by breaking the laws of tapu. Spirituality and wellbeing were inextricably linked as illness was believed to be the result of an act of hara (infringement of tapu), resulting in the ‘withdrawal of spiritual protection’ (Lange, 1999, p.10). Although all Māori were socialised to know and observe oranga tikanga and practices, tohunga (who could be men or women) were experts in rongoā, karakia

and whakapapa (Lange, 1999, p.12). Tohunga were intimately involved in the daily lives of their communities.

Durie lists five types of treatments tohunga could draw upon to heal: ritenga (rituals and karakia), mirimiri (massage), wai (water), surgical interventions and herbal remedies (Durie, 1998, pp.18-20). These techniques were typically used in conjunction with each other to heal both the cause and symptoms of the illness. In instances where an individual became unwell, a tohunga was needed to identify the hara the person had committed and restore tapu (Lange, 1999, p.10). Oranga was maintained daily by observing tapu and noa bounds to ensure harmony with spirits, people and the environment (Durie, 1998, pp.7-10; Mark, 2012, p.30).

Although some debate exists about the extent of Māori knowledge and use of botanicals for disease, Lange argues that tohunga may have treated ‘minor visible ailments such as boils, sores, swellings, bruises and skin diseases’, and understood the value of massage, mud poultices, and hot springs (Lange, 1999, p.12). Indeed, the process of settlement in Aotearoa facilitated the development of a deep and intimate knowledge of the ecological environment, including the healing attributes of plant life. According to Lange, the ‘importance of the efficacy of herbal remedies and the spiritual potency of the accompanying karakia (prayer) both played a part in the treatment process where both external symptoms and the underlying cause were taken into account’ (Lange, 1999, p.14).

Kai Ora

The relationships between Māori and their environment and resources were inextricably tied. Though not nomadic, Māori were a mobile people. In order to secure meat, Māori travelled to hunting and fishing grounds where camps and butchery sites would be built. Common prey were moa, seals, fish, and birds. Moa hunting was especially prolific in the South Island. Sites specialised for moa butchery were most common there, the most frequented area being at the Waitaki River mouth where moa were killed in their tens of thousands (Anderson et al., 2014, p.81). Prolonged physical activity also included gardening and foraging. Shell fishing too had always been a part of food gathering, though this became more prominent in the South Island as seals, moa and other species became extinct or less available. Hapū in the central and southern parts of the North Island faced the same dilemma, so fishing became more prominent in these areas (Anderson et al, 2014, p.86). In order to fish, physical effort was required not only for travelling, catching and cooking, but to fell the timber needed to build waka. For this Māori needed access to forestry, so even the act of fishing required a relationship with the land; both for access getting to the fishing grounds, and access to forestry for boat building. Spiritual considerations overlaid this, and tohunga guided the rituals around catching and processing fish, and its division amongst the group. The same went for the forests where Māori accessed timber for their waka. Each realm was under the dominion of a different atua, so tohunga would also guide the felling of trees and the construction of waka (Durie, 1998, pp.26-27).

As well as mediating with the spiritual realm, Māori were also able to adapt to the physical environment around them to secure their oranga. In these early times of

settlement, the controlled use of fire was a way hapū would adapt their environment. This increased the area where fern could grow. Pith from fern stems and roots from bracken fern were common foods, especially in the earliest periods of settlement. Firing was also important to clear land for cultivation, and to allow weka and quail to flourish. Fire would continue to be used down the centuries, though less frequently as time went by. Sugar was made from the roots and lower stems of cabbage trees—tī kōuka and tī para. Tī ovens were especially common on the east coast of the South Island. In the North Island the tī para was more common and this food contributed to the ‘attritional’ dental health of Māori there. Karaka berries were a nutritious though poisonous food. The poison was removed by soaking and steaming, which also helped the berries to be stored for later consumption. Karaka trees only grew in the North Island naturally, though South Island hapū had learnt to cultivate them there and as far as the Chatham and Kermadec Islands. Other cultivated foods included kūmara, taro, hue (gourd), and uwhi (yam) (Anderson et al., 2014, p.80).

By the fourteenth century, agricultural systems that included storage pits, garden walls, stone lines and marked paths featured from Marlborough to Northland. Hapū adapted their treatment of kūmara to suit the colder conditions in New Zealand. Hapū used walled off areas and other structures with heat-retaining gravel to allow kūmara to grow in New Zealand’s colder climate. Kūmara was stored over winter for food, and for seed tubers for the next season. Another adaptation was the ability to preserve fish, mammal and bird meat with the naturally occurring fats and oils. ‘Containers were made of either bark or the large bladders of bull-kelp protected by a covering of bark’ (Anderson et al., 2014, pp.81–82). Māori adapted the use of kurī (dogs) to hunt moa, since finding moa depended more upon scent of the animal (Anderson et al., 2014, p.85).

The New Zealand climate grew colder during the 15th and 16th centuries (Anderson et al., 2014, p.84). The effect of this was especially deleterious for northern agricultural productivity (Anderson et al., 2014, p.96). Previously villages had been more transient and were occupied for relatively brief periods (Anderson et al., 2014, p.80). Mobility continued to be important for Māori to sustain themselves, however transient villages evolved into more permanent settlements (Anderson et al., 2014, p.98). The basic setup of houses and cooking areas continued, though now there was a rapid expansion in horticulture, and the development of larger roofed storage pits (Anderson et al., 2014, p.89). Kāinga from the 15th century featured ‘planked and carved house(s).’ for rangatira, pole-and-thatch constructed houses for sleeping, as well as palisades, ovens, and hearths (Anderson et al., 2014, p.91). Individual Māori adapted to the colder climate simply by wearing more layers (Anderson et al., 2014, p.142). By 1769 the Māori population is estimated to be between eighty and one hundred thousand, suggesting that the population had expanded significantly in the preceding centuries. This further explains the diminishment of natural resources and subsequent Māori adaptation into larger scale agriculture (Anderson et al., 2014, p.96).

Mana Wāhine

Women and men held complementary roles across political, economic and social spectrums. Men and women were essential parts of a collective whole; both formed

part of the whakapapa that linked Māori people back to the beginning of time, and women in particular played a key role in linking the past with the present and the future. Creation narratives are full of stories of powerful and influential women, from Papatūānuku, the earth mother and ancestress of all Māori, to Mahuika and Hine-nui-te-po. Indeed, women could hold power, land and rank like their male counterparts. Day-to-day interactions between men and women involved mediating between the physical and spiritual, and tapu and noa. The study of a site dating back to the thirteenth century in Palliser Bay showed that a large house there appears to have been set up in a way that separated women and young Māori from senior males and guests (Anderson et al., 2014, p.80). Interaction with the environment and daily routines could also be gendered. For example, men could work plantations of the kūmara which held tapu properties, but women could not. By the late eighteenth century, however, women could work raising potato crops, a new and noa food source. A house would be considered tapu if someone had been sick or died there. The house in that state could not be safely occupied. There women could bring things back into a state of utility, of noa (Anderson et al., 2014, p.165).

The importance of women is also symbolised by language and in whakataukī such as ‘He wahine, he whenua, e ngaro ai te tangata’—‘by women and land men are lost’. The description of women as whare tangata (the house of humanity) also centralises women as givers of life. Evidence shows that ‘on average Māori women bore three to four children’ and, similar to their European counterparts, could expect a general life expectancy of not much more than 30 years (Anderson et al., 2014, p.38). Childbirth was viewed as a tapu process and was separated from normal dwelling houses. Women in some areas would give birth outdoors or in specially constructed whare kōhanga, erected some distance away from kāinga as women (those of high rank in particular). neared advanced stages of pregnancy (Clarke, 2012, pp.20–21). The birthing practice involved upright positions, common in Polynesian and other cultures, but dropped by most Europeans in the seventeenth and eighteenth centuries (Clarke, 2012, p.22). Tohunga would intervene in complicated births, acting as an intermediary between the people and gods. They recited chants and karakia to Hine-te-iwaiwa, the goddess of childbirth, to encourage the baby forth from the womb. Whakapapa was also recited. The combined use of incantations and physical pressure on the uterus aided, according to Clarke, many deliveries. When the whare kōhanga was vacated by mother and baby, the whare was burned and the site blessed by a tohunga (Clarke, 2012, p.22-23).

Oranga Through the Eyes of Pākehā⁶

Early explorers gave accounts of good Māori health, healthy skin and a rapid healing ability—both signs of a good immune system and low incidence of skin pathogens (Hanham, 2003, p.38). Māori were later observed to heal from tattoo

⁶ ‘All of the primary literature produced in the late eighteenth and early nineteenth centuries, regardless of whether it was written by medical professionals or not, was written before there were any major advances in medical science, such as the discovery of microorganisms (Medical science was in its infancy). These limitations have resulted in a number of contradictions, conflicts and inaccuracies in the primary data that have not been widely addressed by the secondary literature... and the [secondary literature also] necessarily relies on European observations of Māori’ (Hanham, 2003, p.4).

wounds at twice the speed of Europeans—signalling a strong, robust Māori constitution (Hanham, 2003, p.40). Pākehā couched their health observations within a critical or romantic ethnocentric lens.

The men are of the size of the larger Europeans, stout, clean-limbed and active, fleshy but never fat, as the lazy inhabitants of the South Sea Isles, vigorous, nimble and at the same time clever in all their exercises (Banks quoted in Hooker, 1896, p.230).

The Natives of this Country are strong, raw boned, well-made active people, rather above the common size, especially the men... They seem to enjoy a good state of health and many live to a good old age (Cook quoted in Beaglehole, 1968, p.278).

The activities of men, women and the rearing of children, also drew comment. ‘Pākehā concerns about the capacity of Māori to care for themselves, and in particular their children reflected western values and standards of care.’ Europeans recorded their early observations according to their own ‘caregiving spectrum’, at one end criticising Māori for their failure to discipline children, and at the other end romanticising the communal approach of Māori caregiving as an idyllic pre-industrial ‘back to basics’ way of caring (Williams, 2019, p.59). Examples of such observations include the following:

They are kind and hospitable to strangers; and are excessively fond of children. On a journey, it is more usual to see the father carrying his infant than the mother; and all the little offices of a nurse are performed by him with the tenderest care and good humour. In many instances (wherein they differ from most savage tribes). I have seen the wife treated as an equal and companion (Earle, 1832, p.257).

The women are... more lively, airy and laughter-loving than the men, and with more volatile spirits. Formed by nature to soften the cares of more serious man, who takes upon himself the laborious and toilsome part, as war, tilling the ground etc, that disposition appears even in this uncultivated state of nature, showing in high degree that, in uncivilized as well as in the most polished nations, man’s ultimate happiness must be placed at last in woman. The dispositions of both sexes seem very mild, gentle, and very affectionate toward each other, but implacable toward enemies, whom having killed they eat, probably from a principle of revenge (Banks quoted in Hooker, 1896, p.233).

With the arrival of Pākehā came catastrophic disruptions to oranga, beginning with wave upon wave of infectious diseases. In turn, cultural frames for understanding and classifying the known and unknown, the old and new, were reworked by Māori to distinguish between traditional and foreign states of wellness and sickness. This clash of ideas about what constituted good care and wellness would unravel over the next 250 years or so. The chapter summary below outlines how the report will trace such conflicts, and how colonization impacted on oranga over the course of two centuries.

Chapter Summary

The report is structured chronologically, with five of its seven chapters focusing on set time periods of the history of oranga and Māori health inequities. The chapters focus on set time periods yet across the chapters common themes arise: Māori assertions of rangatiratanga, calls for autonomy, changes in Māori land and health policy, for example. At the heart of the report, however, is people—Māori men, women and children. Chapters 2-6 are introduced by tupuna who lived during the

timeframe of the chapters they open. They are made present in the report to ensure their voices and concerns are heard. Wāhine Māori dominate these chapter openers, in recognition of the struggles they experienced and the role they play in this history. Mana wāhine is a theme we were unable to pursue in depth in this report. Ko tēnei te mihi ki rātou.

Chapter 2: Disease, Faith and the Politics of Health Care (1769–1859)

This chapter spans the period from first contact with Pākehā to the years just before the New Zealand wars of the 1860s. It focuses on the impacts of infectious diseases, the influence of Christianity on Māori views of oranga, and the policies of health with which Māori engaged from 1840 when the Treaty of Waitangi was signed. The introduction of assimilationist health policies and practices is discussed against the backdrop of diseases. It is here that the tensions between oranga and the western view of ‘health’ emerges. As Māori health policy focuses on infectious diseases, policies around Pākehā settlement see whakapapa, whenua and whānau come under pressure. With the loss of life from diseases and instances of conflict, the tenets of oranga came under attack but remained generally stable during this period.

Chapter 3: Decline and Survival (1860–1900)

This chapter focuses on the massive destruction caused by the Crown’s invasion of tribal territories during the New Zealand wars. It highlights how Māori communities struggled to survive as their land was stripped from them via raupatu and the establishment of the Native Land Court. Poor living conditions made Māori even more vulnerable to infectious diseases and the population of Māori declined. As war stretched across the country, the Māori population decreased, and settler migration increased. By war’s end in 1872, the pressure on Māori communities to retain whatever lands they could was extreme. Yet the alienation of land continued by raupatu. Impoverished and disempowered, Māori struggled to survive in a Pākehā dominated and controlled landscape. The pillars of oranga were placed under extreme pressure during this period, and the concept of whakamā is introduced to describe a cultural response to that pressure.

Chapter 4: He Aha te Mate? The Scars of Recovery (1900–1945)

In 1900 the negative effects of warfare and infectious diseases on Māori communities continue to be felt. This period saw the emergence of leadership that was willing to work within the system to improve the wellbeing of struggling Māori communities. The introduction of Māori councils and a Māori nursing scheme represent an early articulation of ‘for Māori by Māori’. Retaining Māori land also became a strategy of these leaders who recognised that the development of Māori land was central to the welfare of communities. The chapter outlines the state’s ongoing reluctance to fund and otherwise support Māori initiatives towards achieving oranga and addressing health inequities through autonomous councils.

Chapter 5: A Healthy Equality? (1945 to 1975)

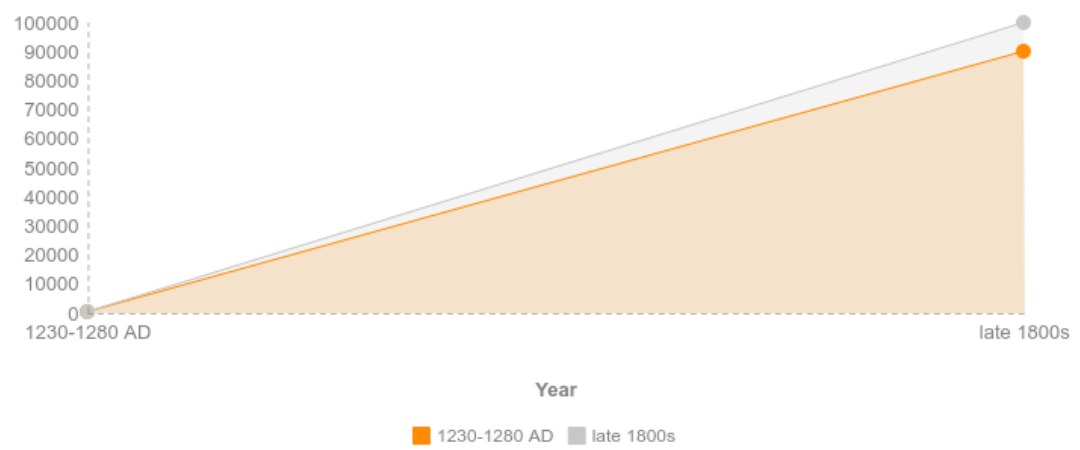
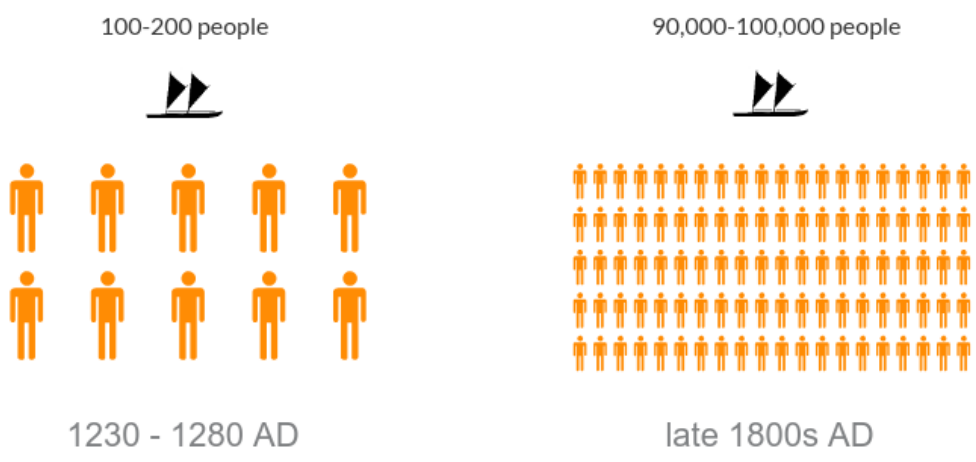
Urban migration became the only viable means by which oranga could be maintained by Māori during this period. It was at once, an active attempt on the part

of Māori communities to support each other and protect their land and connections to it, in response to the state's determination to fully assimilate Māori and put their lands into full production. The state's determination will be presented in an overview of government policies during this period. It will include an overview of the Māori Social and Economic Advancement Act of 1945, policies developed from the Hunn Report of 1961, and a slew of Māori land legislation culminating in the Māori Lands Act 1967. Some gains in Māori health and its indicators were made during this period, but it will be argued that health equity and the broader aim of 'universal welfare' in New Zealand not only failed to transpire, but also became one of the government's rationales for not supporting the establishment of autonomous Māori institutions.

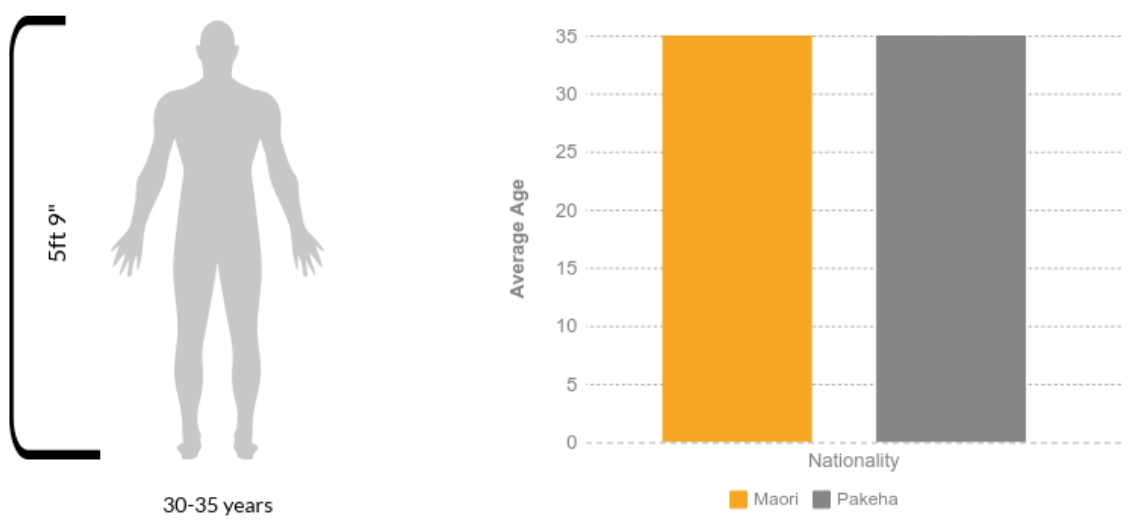
Chapter 6: Healthy Partnerships? (1976 to 1992)

This chapter outlines the huge socio-economic disparities that emerged during this period as New Zealand moved through a period of neo-liberal reform in the late 1980s and early 1990s. Those disparities are linked to rising health inequities. They were alarming and across the board. The chapter also highlights how Māori continued to push for autonomy in the health sector and once achieved, struggled to gain traction due to inadequate funding and rigid administrative requirements. Although Māori concepts of wellbeing were acknowledged and even incorporated into health institutions, it is argued that oranga was under almost the same degree of pressure that it was at the end of the nineteenth century. Whether one lived in urban or rural areas, health inequities existed, and oranga struggled.

Maori Population



Life Expectancy



Maori Land Ownership

Maori Land Holdings



Chapter 2. Diseases, Faith and the Politics of Health Care (1769–1859)

It was under a cloud of disease and death that an elderly woman named Te Hura walked up Pukekohe Hill in Heretaunga (Hawke's Bay). in late 1850.⁷ When she reached the top the spirit of one of her dead children and Moses told her that she had been chosen to heal Māori. In preparation for her calling Te Hura sought out Paul Toki, a local Anglican Māori who blessed her with hot water in order to remove her tapu. By drawing on the powers of Christ and traditional healing methods, Te Hura set out as a prophet and healer to save her people from the devastating diseases hitting their communities.⁸

Throughout Te Hura's lifetime the Māori world underwent tremendous change. When she was born, iwi Māori dominated the tribalscape but by the time she ascended Pukekohe Hill, Pākehā people outnumbered Māori. With Pākehā came a foreign culture replete with its own language, economy, social ideals, religion, technologies and diseases. While Māori learned about Pākehā and sought out the benefits of trade and travel, their concern about the impact of new illnesses ravaging their communities spread apace with the infectious diseases (Durie, 1998, p.26). The Māori population of no more than 100,000 in 1769 had dropped to between 70,000 and 90,000 by 1840. By the late 1850s it had plummeted further to around 60,000 (Anderson et al., 2014, p.200). Inter-tribal warfare in the 1820s played a role in this population decline, but diseases introduced by Pākehā took most Māori lives (Anderson et al., 2014, p.162). In the nineteenth century, Te Hura and others emerged as prophets and healers; a cultural response to missionary teachings, war, disease, and death. Oranga was under attack.

For most of the period under review in this chapter the Māori world continued to turn under the authority of tribal leadership. Oranga—whakapapa, whānau and whenua—was front and centre in 1840 when Māori engaged in Te Tiriti—The Treaty. It was an agreement that Māori perceived would enhance and protect their tino rangatiratanga, whenua, tribal resources and customs. However, colonizers brought with them notions of their own racial superiority. This was applied first by Christian missionaries via their trading, preaching and teaching—all of which were designed to civilize, assimilate and ultimately convert Māori to Christianity. The Crown's proclamation of sovereignty in the English version of the Treaty of Waitangi was also underpinned and driven by notions of racial superiority alongside Western philosophy, laws and values. These in turn shaped the assimilationist health legislation and policies that were to come.

This chapter acknowledges that the arrival of Pākehā and the processes of colonization brought both negative and positive encounters and outcomes. Some Māori communities during this period, particularly in the northern and coastal regions, selectively acquired and incorporated new commodities, technologies and ideas. Some chiefs vigorously engaged in commerce, building businesses and trading a wide range of goods. Some of

⁷Anderson et al., 2014, p.245.

⁸ Goldsmith, 1996, pp.170–71., Anderson et al., 2014, p.286.

those commodities included livestock such as pigs, which bolstered protein-poor diets, while the novelty of tobacco and alcohol provided another commodity that Māori could trade with and consume. New diseases, however, were an imported item that brought nothing but misery and, arguably, a receptiveness for engagement with Missionaries and the Crown that may not have existed otherwise.

The first part of this chapter focuses on infectious diseases to 1840. The story about how diseases impacted on Māori is about more than counting deaths. It is also about Māori resilience and the wider socio-political systems and circumstances in which those diseases were able to take hold. The second part of this chapter focuses on how Māori engaged with missionaries and the informal health care system introduced by them and other early European settlers. From 1814, missionaries (most of whom had no medical training) provided unofficial health care that set the context for 'later official intervention' in the 1840s and 1850s (Dow, 1999, p.13). The third part of this chapter focuses on the politics of health from 1840 to 1859. It highlights how the colonial government was determined to assimilate Māori into a haphazard and underfunded framework of western health policies while at the same time undermining oranga through the assertion of sovereignty and the alienation of Māori land. The outcome, which will set the scene for the chapters that follow, is that Māori suffered the double blow of poor access to western health treatments and the beginning of the erosion of oranga.

Infectious Diseases

Māori enjoyed a reasonably low incidence of disease prior to their introduction by Europeans (Hanham, 2003, p.32). According to Lange, the impact of introduced infectious diseases on Māori health 'was a disaster of unprecedented proportions', caused by a lack of Māori immunity, and an inability to treat these diseases (Lange, 1999, pp.19-20), and by changing social and economic times that made Māori more susceptible to disease. While such factors may have contributed to Māori deaths from disease, additional causative factors have been identified. At the heart of the matter is whether the introduction of infectious diseases could have been avoided. When the Crown decided to actively pursue colonization, did it fail to protect Māori? Colonizing nations were aware of the impacts that came with their contact with indigenous populations, even if there was no clear knowledge about micro-organisms before 1840 (Pool, 1991, p.85).

Looking across the health impacts on indigenous peoples in Australia, Aotearoa, Hawai'i and US Associated Micronesia, Ian Anderson and colleagues (2006, p.1775). conclude that all indigenous peoples in these places 'experienced steep declines in population during the initial phase of colonization as a result of the combined effects of dispossession, social change, and introduced epidemic diseases'. Meanwhile, McLean's 1964 history of public health in New Zealand, which suggests that infectious diseases were a type of free agent disconnected from those who introduced them to indigenous peoples, has been rejected for failing to consider disease without acknowledging social context (Day, 1999, p.181). Warwick Anderson (2007, p.144) notes that the efforts of some historians to discount the impact of infectious diseases on indigenous peoples as somehow 'the natural result of 'ecological imperialism' have been discounted as such rationalization fails to consider the effects on health and social organization of unnatural colonial events like 'warfare, dispossession, and demoralisation'. He adds (p.145) that 'historians of

continuing indigenous illness and disability now are more likely to address the lasting effects of racial discrimination, dispossession, family disruption, poverty, social marginalization, and limited access to health care'. For example, a key role of colonial governments was to keep indigenous peoples away from white settlers when epidemics struck. This meant limiting mobility and isolating communities (Anderson, 2007, p.147). Isolating disease-ridden ships from Māori, however, did not occur.

Between 1769 and 1859, tens of thousands of Māori men, women and children lost their lives as wave upon wave of infectious diseases brought painful and, at the time, unexplainable deaths. Because Māori had no prior exposure to those diseases, they lacked immunity and were thus exposed to an eventual high morbidity (disease) and high mortality (death) rate. Good health did not guarantee individuals could fight infection or rapidly recover. Even survivors who built up immunity over time were still vulnerable to the influenza virus which could mutate and sweep through a community over and over again (Hanham, 2003, pp.47–48). At the time no-one knew what caused diseases, how and why they spread, and how to treat them. Pākehā, however, had some understanding of the portability of infectious diseases having witnessed in other colonial endeavours their impact on other indigenous peoples.

The chronology of the arrival and impact of diseases is important. Prior to 1820, descriptions are vague. According to Hanham (2003, p.61), tuberculosis and venereal disease (especially syphilis) had the greatest impact on Māori health and society. These diseases impacted on Māori morbidity and mortality, as well as on beliefs and practices (Hanham, 2003, pp.13,71). Sexually transmitted diseases such as venereal disease also accelerated the spread of other infectious diseases and had an impact on Māori fertility (Anderson et al., 2014, pp.1, 165). As many Māori women suffered the secondary effects of trauma and infertility, the birth rates of Māori plummeted and threatened the continuity of whakapapa. In addition, influenza and other similar respiratory diseases that swept through Māori communities with increasing frequency pre-1840 made Māori vulnerable to tuberculosis (TB). A brief summary of diseases and the order in which they impacted on Māori is offered below.

Sexual contact was not infrequent between Māori women and European men during the pre-Treaty era. In 1777, Te Weherua, a young Māori man who sailed aboard Captain James Cook's *Resolution*, is reported as saying that venereal disease had been and continued to be common, though it had become less virulent recently (Anderson et al., 2014, p.142). Indeed, venereal diseases hit Māori communities first, with the first mention of an infectious disease in New Zealand recorded in 1770 in Queen Charlotte Sound. Cook noted its introduction to Māori on his voyages (Rountree, 1998, p.38). Hanham (2003, p.61), however, attributes its introduction to French explorers who visited Northland twice in the 1770s. Regardless of who introduced venereal diseases, the ships that brought it meant it was more common in coastal settlements than inland. In the 1790s, one sexually transmitted disease known only as 'tingara' ravaged the Bay of Islands around 1795 (Anderson et al., 2014, p. 167). Indeed, between 1820 and 1830s, most evidence about sexual activity and venereal disease comes from the Bay of Islands. Its prevalence would have been exacerbated by the Bay of Islands being a 'resort' for sealers and whalers, and 1820s warfare that increased the number of slaves in the region.

According to [Edward] Markham in 1833 there could be four hundred to five hundred sailors in Kororāreka looking for women at any given time. Most of the men were off-shore whalers who had been at sea for at least a year and many women spent three weeks or more on board the vessels while they were in the harbour. This continued and prolonged contact would have paved the way for a high incidence of venereal disease (Hanham, 2003, p.62).

As the symptoms of gonorrhoea could lay dormant, it is believed that most reports of disease were observations of syphilis, the behaviour of which had been observed when it first emerged in America and then spread to Europe around 1495. The possibility that the disease had a devastating impact upon its introduction to New Zealand is quite high. According to Diamond, epidemiologically syphilis behaved like a new disease when it was introduced and was so virulent that it could lead to death within months (Hanham, 2003, p.64). The impact of this disease must have been shocking and frightening to Māori exposed to it. The symptoms of syphilis began ‘with genital sores and then a general rash, followed by ulceration and abscesses eating into bones and destroying the nose, lips and genitals, often ending in death’ (Porter, 1997, p.166). There are specific syphilis cases described in the literature, the earliest being from John Nicholas in 1814:

At Paroa he saw a woman whose face, hands and whole body were a mass of running sores and fetid ulcers (Nicholas, 1817, pp.38–39). At Rangihoua he saw another woman who seemed to be happy, cheerful and vigorous, although her hands, face and body were in a state of livid ulceration (Nicholas 1817, p 130–131). In 1820 McRae saw one woman who died and one who was dying of venereal disease (McNab, 1908, p.541). The case of Te Wera in the South Island is the only case found in the literature where the victim was a male (in Hanham, 2003, pp.64–65).

According to Hanham (2003, p.65), Māori were aware that venereal diseases came from intercourse with Europeans (calling it the European god, according to Dr Fairfowl) and they created a system in which those affected could be quarantined from the general population. The services of young female slaves were sold to European men on-board ships (Hanham, 2003, pp.62, 65). The slaves were then regarded as tapu and thus off-limits to Māori men because they may have been given the disease by the European atua. When women were aware they had syphilis, they left the ships and returned once they had been cured. A steaming method with indigenous plants was said to be effective if it was done when first lesions appeared (usually) on the genitals (Hanham, 2003, p.67). In these ways Māori attempted to contain the disease (Hanham, 2003, p.65–66) (but not so the spread of it to Europeans). This type of quarantining was still practiced by Māori in 1839 (Hanham, 2003, p.66). Another way in which Māori attempted to limit the impact of disease was through the deliberate termination of pregnancies, which would have curtailed the number of babies born with congenital syphilis (Hanham, 2003, p.67).

While venereal disease, especially syphilis, would have had a long-term impact on Māori, attempts by Māori at the Bay of Islands would have been reasonably successful at containing the disease, and the virulence of the disease would have reduced over time as it did in Europe (Hanham, 2003, p.68).

By the early nineteenth century the major causes of death were from influenza, whooping cough, measles and dysentery. Māori referred to ‘rewa-rewa’ or ‘rewha-rewha’, which may have included both influenza and dysentery.⁹ This was thought by Colenso to have

⁹ In present day Kaikohe rewha-rewha describes any respiratory disease, including asthma.

killed 60 percent of Māori in the southern North Island, although the source of this figure is unclear (Anderson et al. 2014, p.165). In 1808, a possible typhus epidemic hit Whangaroa. Māori connected the epidemic to an incident where the captain of the *Commerce* dropped his watch into the harbour accidentally. When a similar incident happened in 1809 in the Bay of Islands, Māori feared the ‘watch atua’ would plague them as it had done in Whangaroa (Hanham, 2003, pp.50–51). Such incidences speak to Māori seeking to understand and explain new infectious diseases within their own worldview.

From the 1820s, as Māori contact with Europeans increased, so too did reports of tuberculosis, catarrh, whooping cough, measles, mumps and polio (Hanham, 2003, p.45). Ships transported diseases from port to port, including from Australia to Aotearoa. One epidemic, thought to be catarrh, arrived at Kororāreka on the ship *HMS Dromedary* from Sydney. Three Māori had already died at Parramatta, and three people died on the ship. At least one other person living on the ship at Kororāreka became ill. The ship travelled to Waitematā and Hauraki, and then to the Coromandel (Hanham, 2003, pp.52–53).

Ships arriving in the Hauraki Gulf could introduce infectious diseases that then proceeded to spread inland. For example, an epidemic believed to be introduced by the ship *Coromandel* in 1820 killed a number of Māori as it passed from tribe to tribe until it reached Taranaki. ‘Many thousands are said to have perished’, with the tohunga in Taranaki being unsuccessful in his attempts to counter the illness. The people of Taranaki named the epidemic Te Ariki (Hanham, 2003, p.53).

At times news of epidemics was slow to emerge from communities that had suffered devastation and loss, including the loss of leaders.

It was not until 1827 that Toupaia told Dumont D'Urville about an epidemic that had occurred in the Hauraki region in 1820. The previous chief had been Houpa, who with many of his warriors succumbed to the epidemic. The settlement of Wai Kahouranga at the mouth of the river Thames was abandoned after the epidemic and all the homes were put under tapu. The village was re-established to the south at Hauraki Bay (Hanham, 2003, p.53).

In 1827, an influenza epidemic in several regions was fatal for children and the elderly. The disease entered at Bay of Islands in 1826 from across the Tasman and led to many people ill and many people dying. The epidemic raged through Māori throughout 1827. People believed the epidemic came from *The Research*, with the vessel travelling to a number of ports (Hanham, 2003, pp.53–55). The following year whooping cough hit the Bay of Islands, killing many Māori (Anderson et al., 2014, p.166). It is believed to have come off the ship *Morley*, first infecting mission children and then Māori at Kerikeri and ‘Haumi’, with many dying. ‘Rev Davis recorded that Māori believed that the European god had been responsible for the deaths’ (Hanham, 2003, p.56).

In 1827 reports began to appear about the impact of tuberculosis, with the missionary William Williams recording in 1829 that it was killing many natives, and reports through the 1830s describe an escalating disease. Tuberculosis was a particularly difficult disease to contain, the causative micro-organisms could be contracted days after an oblivious mobile carrier had left the area or spread via simple proximity to a carrier. They could be spread through saliva, dust, sneezing, coughing, hand to mouth passage and drinking

vessels. By the end of the 1830s reports that Māori were a dying race are attributable to the impact of tuberculosis on the population (Hanham, 2003, p.70).

The main impacts of tuberculosis, influenza and measles occurred in the 1830s and later (Anderson et al., 2014, p.166). In 1835 an outbreak of measles in the South Island affected the whaling industry there as entire families suffered sickness and death. Prior to this epidemic, local Māori had resisted the establishment of whaling and sealing stations along the southern coast. However, the shift in balance of power and land ownership that came about because of the devastation of the Māori workforce of the largely Māori controlled whaling industry meant that smaller, previously opposed, whaling stations could establish themselves (Hanham, 2003, p.58). In the same year—1835—an influenza epidemic moved across the country, causing sickness and death. Another influenza epidemic then followed in 1838, following the arrival of the ship the *Coromandel* at the Bay of Islands (Hanham, 2003, p.55). At the Wesleyan Mission in 1838, Hobbs recorded his shock at the decline in the Māori population in the Hokianga (Owens, 1972, p.430). By 1840 the Māori population declined by 10–30 percent largely due to introduced diseases (including loss of access to food) (Lange, 2018, p.1), and ‘it is... possible that infectious diseases had a long-term impact on the overall age of the population’ (Hanham, 2003, p.59).

Indeed, it is important to note that infectious diseases impacted every tribal area differently and the impact was often based on their geographic location. Isolation could protect communities. Thus, tribal groups located inland were less exposed to some of these diseases pre-1840 (Pool, 1991, p.46). As the remainder of this chapter and the following chapter will show, diseases would continue to ravage Māori communities throughout the nineteenth century and beyond. Infectious diseases wrought terribly painful and stressful deaths, impacting on whānau wellbeing, whakapapa and the retention of whenua for decades to come. While the primary outcome of disease was usually the most severe (i.e., the death of thousands of Māori), the secondary effects included infertility, birth defects, and increased risk of chronic illness and disease. Pool (1977, p.95) highlights the decline in the Māori birth rate due to sexual transmitted diseases introduced by early contact with sailors. Hanham (2003, p.67) describes infanticide by Māori slave girls to reduce the impact of congenital syphilis. Such repercussions could contribute to decades of health issues. More severe future health consequences were understood with the emergence of disease epidemiology and the unlocking of the nature of trauma on the mental capacity of people. In the 1840s germ theory began to replace miasmatic theory (i.e., disease caused by environmental conditions) in western understandings of infectious disease (Hanham, 2003, p.5) but attempts at quarantining would not begin until the 1850s.

It is difficult to know the extent of population loss due to introduced infectious diseases between 1769 and 1840. One estimate calculates that ‘from around 100,000 in 1769, the Māori population had declined by 10–30% by 1840. This was largely due to introduced diseases, and the effects, direct and indirect, of the Musket Wars, including dislocation from lands that were important for agriculture and which provided access to mahinga kai (food resource areas).’ (Lange, 2018, p.1). Despite the loss of many lives, iwi Māori continued to exercise rangatiratanga. They were industrious and entrepreneurial. Flax and timber were traded. During the early period of whalers and sealers, rangatira secured

payments of livestock and manufactured goods (Anderson et al., 2014, p.202). Chief Eruera Maihi Patuone of Ngāti Hao of Hokianga travelled to Sydney and organized the establishment of a trading depot and shipyard in Te Hōreke which would become a major centre of timber trade (Anderson et al., 2014, pp.202–203). Potatoes were grown in vast quantities. Chief Ruatara developed a plan to establish and grow wheat, for his own people and for trade. This industriousness and leadership were always aimed at increasing the wellbeing of the collective group (Anderson et al., 2014, p.190). By 1814 that also entailed welcoming missionaries into their communities.

Maintaining Faiths

The arrival of missionaries in the early nineteenth century should be considered within the context of Māori communities that were already accustomed to Pākehā explorers, traders and goods, as well as infectious diseases. Although the main aim of missionaries was to convert Māori to Christianity, initially much of the motivation behind Māori engagement with the missionaries was to build on trading relationships, acquire new technologies and encourage settlement within tribal areas. Missionaries presented rangatira with opportunities to enhance oranga, which entailed Māori assessing new ideas and commodities and either rejecting or adapting them to fit in with traditional customs and beliefs. The first mission station was established at Rangihoua in 1814. Under the patronage of Ruatara, Samuel Marsden of the Church Missionary Society established a mission school and introduced new farming techniques and literacy to the area (Anderson et al., 2014, pp.190-191).

Māori chiefs also showed interest in the belief systems of Pākehā. The incorporation of bible narratives, which themselves were creation narratives, and the incorporation of another atua into tribal whakapapa was not a stretch for iwi Māori. The arrival of missionaries from other denominations—the Wesleyan-Methodist Missionary Society in 1823, and the Catholic Mission in 1839 added to the mix of faiths. Hapū did not immediately convert to Christianity. Māori were also wary of the missionaries, attributing diseases to them and their gods and/or questioning whether the outbreak of diseases in their communities was punishment from their own atua because they had engaged with the Christian god (Anderson et al., 2014, pp.197-198).

Christianity did not necessarily impact negatively on oranga, but Māori simply had little motivation to convert to Christianity or commit to one particular religion. The provision of muskets to Hongi Hika by Samuel Marsden in 1818 contributed to a power imbalance among tribal groupings already engaged in a prolonged process of inter-tribal battles. About 20,000 Māori are thought to have died (directly or indirectly) from these wars that became more concentrated from 1818 into the 1820s (Anderson et al., 2014, p.186). Although muskets may have increased the death toll, the provision of muskets by missionaries did not significantly disrupt customary ways of maintaining oranga in the long-term. At that time, the practices of utu (retribution) and tribal warfare were part of the balancing act of oranga, whereby tribal territories were claimed and defended, along with the mana of rangatira.

More important to the focus of this report is how missionaries purposely undermined some of the core foundations of oranga in order to civilize and then convert Māori to

Christianity, and the ways in which Māori in turn used Christian religion for the purposes of fighting against diseases and the loss of land. That loss of land and the ability to retain control over it would become an increasing concern for Māori in the nineteenth century. Furthermore, whereas infectious diseases infiltrated Māori communities and created visibly swift and tragic outcomes, missionary and eventually state attempts to assimilate or ‘civilize’ Māori into Western modes of thinking and living also infiltrated Māori communities with long-lasting and equally negative results. Arguably the ability of missionaries and the state to do so was facilitated, if not made possible by the ravaging Māori experienced at the hands of infectious diseases. How those church and state aims, underpinned by racial, ethnocentric and paternalistic ideas, infiltrated informal and formal Māori health approaches and legislation and policies are discussed below.

Missionaries and Informal Health Care to 1840

Traditionally, Māori distinguished between diseases that spread rapidly - tokotoko rangi - and non-contagious diseases—tokotoko tao. This is demonstrated within a waiata cited by Durie:

Tokotoko tao
 Kotahi ki turanga;
 Tokotoko rangi
 Ka ngaro te kai
 Ka ngaro te tangata

The spear of wood
 one at a thrust;
 The spear from heaven,
 food disappears
 man disappears (Durie, 1998, pp.31-32)

Whether contagious or not, disease was 'largely attributed to spiritual causes.' (Durie, 1998, p.31). As such, mate atua was the term given to this spiritual understanding of epidemiology, so by the early nineteenth century debate was had over whether these diseases originated from the Pākehā god, or from disturbances in the more traditionally understood matters of disturbances to tapu and mana. In terms of the former, an understanding of the Pākehā god was required to overcome those illnesses. The missionaries were an obvious source of that mātauranga (knowledge) and so the content of missionary discourse was important in that context. They preached of ‘immorality’ and ‘sin’ as the origin of disease. Consequently, the cure was to convert spiritually and to adjust ways of living (Durie, 1998, p.32). So, though Māori at this early stage were not subject to the more formalised processes of colonialization that would occur in later decades, introduced diseases created a Māori openness to western spirituality and modes of living.

From 1814, Māori requested, and missionaries (who mostly had no medical training) very willingly provided, unofficial health care which set the context for ‘official intervention’ in the 1840s and 1850s (Dow, 1999, p.13). One remedy offered by the missionaries that appeared effective was the use of cod liver oil and iodine in the treatment of scrofula (lymphatic tuberculosis) (Owens, 1972, p.424).

The missionaries held two schools of thought about the impact of infectious diseases on Māori. The first was that it was inevitable, the will of god, and a demonstration of the survival of the fittest. The second drew on ethnocentric views and typologies that highlighted deficits in Māori culture. They were deficits that could be overcome through the benefits of civilization. Both explanations placed the blame for illnesses on Māori ways of living, thinking, dressing, and so on:

Illicit sexual relationships, that is a very evil thing, but to my way of thinking the evil is not only the man's doing—it is partly the woman, and you are all partly responsible. You all believe in sleeping communally, sleeping any old way and any old how—the men, the women, the girls, the married people and the single—all sleeping together in one house, like pigs do!

Another thing is that you are holding onto your women and not properly arranging it that they are given in how matrimony to one husband each. Nor, the result of this communality and withholding is adultery and fornication. No, you are all responsible for the evil, not just the woman or the man, and not only the two of them; all alike are in error. Therefore, don't just punish the one on this account, because you are all guilty (Missionary. Joh Whiteley, 1869, quoted in Head, 2006, p.36).

Owens (1972, p.419) writes that missionary accounts of the period are full of 'evidence of Māori social conditions, of the diseases which affected them, the medical resources available and of attempts to improve diet, clothing, housing and sanitation' (1972, p.419). Missionaries often commented that Māori had inadequate food or were starving, were worked too hard in the timber trade, and neglected their own pigs and plantations (Owens, 1972, p.429). The tendency to view Māori illness as an inherently 'Māori problem' began during this period. But it was not a view held solely by missionaries. By the 1830s, Crown officials became increasingly involved in te ao Māori. Throughout this period, however, hapū communities controlled the bounds of their communities, under the rangatiratanga of their chiefs.

Rangatiratanga was exercised in 1834 and again in 1835 when Northern Chiefs came together under a 'United Tribes' alliance. Although the underlying purpose of British encouragement for such a political tribal formation lay in their own desire to gain authority in New Zealand, the rangatira viewed the selection of a flag on their own political terms and for their own (especially trading) purposes. The flag they selected was named the United Tribes flag, the symbol of a union that was further formalized in 1835 when 34 northern rangatira signed the Declaration of Independence (Ministry of Justice, 2013, p.108). Known as He Whakaputanga, they declared New Zealand was a sovereign state, the power of which was held by them collectively. In 1840, many of these northern chiefs would gather again at Waitangi to reaffirm their rangatiratanga, while the British would seek sovereignty.

Oranga and the Politics of Health, 1840–1859

Te Tiriti—The Treaty and Politics of Health, 1840

The British were initially hesitant to make New Zealand a formal colony. However, a number of factors pushed the idea forward: with or without the Crown's approval, growing land speculation by the Wakefield Company suggested that colonization was taking place with a growing number of British citizens trading and planning to live in

New Zealand. Māori appeared to be a receptive indigenous population. And, then, there was what Durie refers to as the contradictions of a ‘colonizing spirit’. British settlers and colonial officers were ‘participants in a global economy’, ‘fiercely Euro-centric’ and any humanitarianism they held ran parallel with exploitative tendencies (Durie, 1998, pp.28-29). In 1839, Lord Normanby, believing that ‘British humanitarianism, by way of a Treaty’ could negate the negative impacts European imperialism had imposed on indigenous populations elsewhere, sent instructions to Governor Hobson that Māori were to be pressed towards European concepts of civilisation. Thus, the stage was set for Te Tiriti o Waitangi—The Treaty of Waitangi (Durie, 1998, pp.28-29).

On 6 February 1840, over 40 Māori rangatira gathered with Crown representatives and placed their mark on Te Tiriti o Waitangi—The Treaty of Waitangi. Almost half of the rangatira present had signed the Declaration of Independence five years earlier. Te Tiriti is probably the most contested historical document in New Zealand’s history. It is comprised of two versions, in English and te reo Māori with the (contested) translation of the crucial terms of sovereignty and rangatiratanga, kāwanatanga and governorship. This report does not intend to unravel the many interpretations of and debates about Māori understandings of the Tiriti and Treaty. But, within the context of oranga, it is doubtful that Māori would have ever ceded their rangatiratanga or tribal sovereignty over their whakapapa, whenua and whānau.

Treaty discourse has developed over time to encompass the principles underpinning the Treaty. At the very least, it seems, the Treaty recognized a partnership relationship underpinned by the equality of both parties and their cultures, and a future in which both Māori and the Crown would share in the benefits of their ongoing relationship in New Zealand. Te Tiriti promised Māori their rangatiratanga, control over their customary ways of living, and the ownership and use of all lands and resources that maintained their oranga. Māori were also promised equal access to the benefits of British citizenship, including (by the following year) access to health care.

Ani Mikaere argues that equality inherent in full citizenship rights as promised in Te Tiriti is not demonstrated in the disparities in health experienced by Māori (Mikaere, 2011, pp.150-4). The remainder of this report aims to identify such disparities and highlight how the right to exercise rangatiratanga over oranga—to maintain and enhance whakapapa, whenua and whānau—was impacted by the state.

Despite Māori understandings of the Tiriti, following its signing the Crown proclaimed sovereignty over New Zealand—Britain’s newest colony. But it was hardly substantive sovereignty during this period. Māori continued to engage in trade and the business enterprises that enhanced the mana and wellbeing of their communities. In the Bay of Islands, especially, Māori were able to produce large amounts of surplus food. This increased their ability to provide manaaki for manuhiri, a common mana-enhancing activity (Anderson et al., 2014, p.205). Vincent O’Malley writes of a ‘booming’ economy, at least until the economic downturn of 1856 (O’Malley, 2019, Kindle Edition, p.2611 of 3357).

In the 1840s, however, flashes of conflict marked the first phase of the New Zealand Wars, beginning in Wairau in 1843 and ending in Wellington in July 1847. In 1845 an outbreak of war occurred in the North over the limits of authority the Crown and Māori

believed they held. The wars that broke out in the north were a harbinger of greater conflicts to come. Hone Heke, the first to sign the Treaty, was also the first to challenge the new government by force (Anderson et al., 2014, pp.231–232). In the future, others would challenge the government through courts of law. The Constitution Act of 1852 established an elected General Assembly (now known as the House of Representatives). This Assembly had the power to make laws for the ‘peace, order, and good government of New Zealand’ (Ministry of Justice, 2013. p.111). Although section 71 provided for self-governing Māori districts, Māori attempts in the future to use that clause would fail. As the next chapter will show, Māori assertions of tribal autonomy and any type of permanent control over their own welfare would not be tolerated by the state. As Pākehā and infectious diseases entered New Zealand by the shipload, leaders began to apply strategies designed to protect oranga.

Māori quickly appreciated the creeping erosion of their authority and growing pressure to sell land during the 1850s. They began meeting in ‘district-wide’ rūnanga to form an approach to those challenges. Rūnanga were held in Waikato, Hawke’s Bay, Poverty Bay and Rotorua. With assimilation came literacy and the power of letter writing. Through letter writing campaigns Māori sought to spread knowledge, news and garner support for their political movements of resistance. Demands were made to have Māori have equal political status as settlers but to no avail. It is from this ferment in 1858 that the Kīngitanga emerged in the Waikato under the leadership of the Pōtatau Te Wherowhero (Anderson et al., 2014, pp.250–1).

I say, stop trusting the Queen. Consent to the King. Thus I write to you. Tairaroa has consented to King; also Ngāti Raukawa, Ngāti Whakauae, Tūhorurangi and Ngāti Kahungunu; that one at Te Wairoa has also agreed to the King. Thus I write to you. Hear this. End your support of the Queen. Do not persist in selling land; leave the land for our children. Soon everyone will support the King (McLean Māori Letters, quoted in Head, 2006, p.31).

To me, land is man’s parent; without land mankind will not survive (Te Puni to McLean and Governor, 12 October 1852; in Head, 2006, p.176).

All the while, infectious diseases continued to spread, communities continued to lose people, and Māori increasingly engaged with if not pursued Christian gods and western medicine.

Healthy assimilating

Some historians emphasise that Māori health was one of the factors behind the Crown’s decision to enter into a treaty with Māori (Durie, 1994, p.82). Damon Salesa (2001, p.16) argues that doctors were key players of a ‘new colonial order’ as they sought to avoid the decimation of indigenous peoples—an outcome of previous colonizing practices—by finding a humanitarian way to ‘govern the New Zealanders [Māori], without destroying them’. Western medical institutions, practices and doctors, therefore, were part of a body politic, the medical services of which was relied upon to negotiate successful colonization (Salesa, 2001, p.16). However, the full assimilation of Māori into western health services required those services be accessible and effective enough to draw and lock Māori into them. That was not possible at this time because the health system on offer was characterised by inconsistent funding and administration.

Initially, Māori health was centrally funded and consisted of a small number of subsidized doctors known as Native Medical Officers (NMOs) who were informally supported by missionaries (Dow, 1999, p.15). The introduction of these NMOs in the 1840s came without expectation that Māori contribute to fees paid. However, the issue of how or who would pay for Māori health would be debated over the decades and an expectation developed that Māori health be funded through Māori land sales (Dow, 1999, p.45). The difficulty faced by those working at the coalface is illustrated by John FitzGerald, an NMO, who appealed in 1843 and 1844 to the Colonial Secretary for payment. In 1844, FitzGerald had made 600 visits and submitted an invoice for £20, though £60 was closer to the true cost. Such was the confusion of that time that he left blank the payer section because he did not know who to bill (Dow, 1999, p.36). Eventually, Resident Magistrates became responsible for administering NMO funds and they too found themselves underfunded. In Russell in 1855, a cash-strapped magistrate asked the NMO there to suspend distributing medicines unless absolutely necessary, such were the restrictions of his budget. That year the NMO often received more than 50 requests for assistance per day and was spending £21 per month. The target set by the Auditor-General was £6 per quarter (Dow, 1999, p.38).

Underfunded, Māori health services would remain ad hoc throughout the 19th century. Missionaries, Native School teachers, Native Medical Officers and doctors would all have roles to play in administering assimilationist health policies to Māori. Early on, mission stations were often used as de facto hospitals, thereby providing missionaries with opportunities to spread their Christian and Western values (Dow, 1999, pp.21–22). This dynamic would manifest over the decades through more secular institutions as government Māori health policies changed and evolved.

Māori perspective of hospitals

Within a decade of the Treaty of Waitangi being signed, doctors were also treating Māori within newly established hospitals, described by Salesa as the ‘most important’ primary health institutions and modes of amalgamating Māori and Pākehā (Salesa, 2001, p.17).

With infectious diseases decimating communities, Māori not only sought treatment and advice from doctors within hospitals (Dow, 1999, pp.40–41), but at times petitioned for hospitals to be built close to their communities. Dow cites Alan Ward who argues that Grey used the provision of health care as a part of wider political programme for rewarding chiefs and tribes who had supported land sales (Dow, 1999, p.26).

Although there is evidence that Māori did want hospitals, there is also evidence of scepticism and aloofness. In September 1847, New Zealand’s first hospital opened in Wellington. A week later the colony’s first surgery using general anaesthetics was performed on Hiangarere, a rangatira from Waikanae (Dow, 1999, p.27). The success of this surgery may have allayed any fears Māori held. In the years to follow, Māori were the majority of patients in both Wellington and New Plymouth hospitals. The first report of the Medical Superintendent even noted that some Māori feigned continued illness in order to remain longer in hospital (Dow, 1999, p.28).

Māori would find though that their willingness to engage with western medicine did not necessarily mean that it was forthcoming. In 1850 Ngāti Pikiao and Ngāti Tararua gave

land for a hospital during a rūnanga hui held at Te Rotoiti. However, no hospital was built in Rotorua until 1886, followed by the King George V Hospital in 1916 (Dow, 1999, p.62). A similar situation existed in the South Island where Ngāi Tahu had been offered schools and hospitals for land ceded in the 1840s and 1850s. The hospitals, at least, were never established. Instead Māori were to use public hospitals, since they were equally available to Māori as to Europeans—at least according to the conclusion of a committee investigating the Middle Island Native Claims in 1889 (Dow, 1999, p.68). An expectation existed among many South Island Māori that medical treatment was forthcoming under the ‘tenths’ provisions of the nineteenth century land sales. This system set aside Native Reserves, referred to then as ‘tenths’, and was another way Māori health was funded. However, the Health Department in 1921 ‘asserted that the Ngāi Tahu tenths contained no express provision for hospital or medical treatment (Dow, 1999, p.177).

Māori acceptance of hospitals and western medicine was neither ubiquitous, nor permanent in areas where engagement was initially forthcoming. By 1851 four hospitals had been built and all were well utilized by Māori. New Plymouth hospital opened in 1848 and nearly all the inpatients were Māori (Dow, 1999 p.28). However in 1857 an unnamed Māori patient died, and though no detail is given, New Plymouth hospital was deemed tapu. News of this spread and soon the same was true of Wanganui hospital (Dow, 1999, p.31). In fact the 1860s saw a general decrease in Māori seeking hospital treatment. Dow points to the general disruption caused by the wars of this period, and the continued adherence of Māori to tohunga. Various colonial officers reported that Māori would utilise hospitals only when the tohunga could not cure the patient, by which time they were beyond helping (Dow, 1999, pp.64–65).

Vaccination

Initially, Māori health policy was aimed at reducing the impact of disease through vaccination and sanitary improvements. In 1854 the Central Board of Vaccination organised the vaccination of Māori by clergy and public vaccinators. Although an 1849 pamphlet on smallpox that was written in te reo prompted Māori to request vaccination, Māori were not seen as capable of managing this task themselves (Day, 1999, p.182). What may appear to have been genuine concern for Māori health is also often undermined by colonial views about how vaccinating Māori was viewed as necessary to protect the health of colonists. Officials acknowledged that smallpox was more virulent and fatal for Māori, but they had little faith in Māori habits and knowledge to slow the spread of it (Day, 1999, p.183).

All concurrent testimony goes to prove, that in the coloured races of men, smallpox is more virulent and fatal than in the fair skinned races, while among the savages, their personal habits, mode of life, and ignorance of proper treatment combine to disseminate the disease with frightful rapidity, and give it a most malignant and exterminating character’ (Auckland Provincial Council (APC), Report of the Select Committee of Vaccination. 1858, Session VIII, p.258, quoted in Day (1999, pp.182–183).

The distribution of smallpox vaccines among Māori showed that the colony did not consider that it was merely smoothing the pillow of a dying race (Dow, 1999, p.48). An early example was the vaccination of Māori in Taruheru (Gisborne) by missionary William Williams in 1845. Three years later a migrant ship with passengers infected with

smallpox arrived in Wellington. Vaccination was made available, though Māori there were initially sceptical. Here Edmund Halsell, NZ Company Protector of Aborigines, self-administered the vaccine publicly to convince local Māori to accept vaccination for their children. Still, some remained aloof, while others were in such a panic that they were self-vaccinating, with poor results (Dow, 1999, p.51).

It was reported in 1859 that two-thirds of Māori had been vaccinated for smallpox, although evidence of this or of the effectiveness of it is unknown (Dow, 1999, p.52). Even so, a subsequent decline in the incidence of the disease was accompanied by a decline in initiatives to vaccinate Māori. As discussed in the next chapter, the 1863 Vaccination Act was the first piece of public health legislation that applied to all residents and was similar to legislation passed in Britain. It was the first attempt by the government to prevent, rather than merely quarantine, infectious disease (Day, 1999, p.180).

Funding for Māori health was drawn from the ‘Civil List’ under the Constitution Act 1852. An annual payment of £7000 was allocated for Māori purposes, a figure which would not change for nearly a century (Dow, 1999, p.16). In 1854 Provincial Secretary of Wellington William Fitz Herbert sought to put Māori health on a more ‘systematic colony-wide footing’, and key to this was funds to be drawn from the £7,000 allocation (Dow, 1999, p.39). This was supplemented by Native Reserve trust monies. Yet the way these funds were administered remained haphazard (Dow, 1999, p.58). Indeed, the passage of the 1852 New Zealand Constitution Act complicated the relationship between Māori and hospitals. Responsibility for Māori health, which began with the central government, was then shifted to the reluctant provincial governments, and back again later on. This was all happening at the time when the European population was increasing rapidly (Dow, 1999, p.57) and consequent pressure for land for new arrivals was increasing too.

In 1856 Dr I.E. Featherston declared ‘The Maoris 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’ (Sutherland, 1940, p.28). Sutherland then describes how Dr A.K. Newman made the same prediction in 1881 but, without any fear of reproach, saying ‘the disappearance of the race is scarcely a subject for much regret. They are dying out in a quick easy way and are being supplanted by a superior race’.

The successes and failures of the government’s actual provision of health care in this time period, post 1840, were consistently undermined by poor administration and the failure to commit adequate funding and resources to the task. By the 1850s, as the settler population matched that of Māori, an additional and persistent factor in the provision of health care to Māori was how the government often acquiesced to settler health needs and demands at the expense of Māori who sought and expected access to doctors and hospitals.

Early Erosion of Oranga—The Whenua

Whatever humanitarian motivation had existed leading into the Treaty faded quickly as the Colonial Government focused on bringing as much as land possible under Crown control for sale to settlers (Anderson et al., 2014, p.237). As Māori faced increasing

pressure to sell land to the growing number of settlers, complications within and across tribal boundaries also arose. In Kaikohe and Waima attempts were made to prevent land sales but were often unsuccessful because of the emergence of ‘Pākehā land-jobbing’, a land-buying approach that fed into the mana-enhancing activities of rangatira who competed with other rangatira to sign deeds of sale and receive payment for land first.

In 1846, Grey was instructed by London to bring any lands not under direct occupation by Māori—known as waste lands—under Crown ownership. The assumption was that Māori did not own lands that they accessed seasonally for kai. Mobility was an important part of oranga Māori in that it allowed them to access a diverse diet (Anderson et al., 2014, p.247). Grey embarked on an aggressive purchasing programme with a focus on chiefs believed to be partial to selling land. Often though, multiple parties had interests in a single land block, and not all were consulted about land sales (Anderson et al., 2014, pp.247–248).

Part of Greys land purchasing policy included the abolition of the Protectorate of Aborigines in 1846, a ‘semi-independent body’ that sought to protect Māori interests. One result was the impoverishment of Ngāi Tahu, who were left landless after the Crown acquired 34.5 million acres of their whenua. Many Ngāi Tahu continued to believe that they held ultimate ownership, so continued to hunt and fish in areas that would soon be fenced off by Pākehā farmers and settlers (Anderson et al., 2014, p.248).

The Kingitanga

In 1858 the Pākehā population reached the point where it outnumbered the Māori population. That year the Kīngitanga movement was also established to create a unified tribal response to increasing pressure to sell land, and as a means of establishing a Māori sovereign leader equal in status to the Queen of England. However, not all tribal groups aligned with the Kīngitanga. As O’Malley (2019) points out, prior to the 1860s tribal authority was exercised within hapū communities which were ‘largely self-governing’. There was no ‘single Māori political entity’ (O’Malley, 2019, Kindle Edition, p.265 of 3357).

Nourishing Oranga—Building Economies

Bouts of conflict during this period reflected Māori concerns about the security of their communities, and how rangatira could maintain authority over their tribal rohe and whenua. The establishment of the Kīngitanga in 1858 illustrates how deeply and widespread those concerns were becoming. The whenua had deep cultural meaning, reinforced identity, nourished communities, and provided one’s place in the world. However, it was also the basis of burgeoning hapū commerce during this period. Amid the spread of disease and the trauma that came with it, many Māori communities engaged in very new and lucrative market economies. It was a continuation of pre-Treaty tribal commerce that could range from the whaling industry in the deep South, to gold mining, wheat growing, farming and gum digging gum and timber milling in the Far North. These economies were continually at risk by pressure to sell land and, by 1855-6, a massive decline in the export market.

Indeed, around the time Te Hura climbed Pukekohe hill, an economic depression loomed. Export prices to Australia fell when many Māori entrepreneurs held large debt from capital investment. The impact of the market decline on hapū industries would have been felt in diverse ways and according to their locality and the markets in which tribes were engaged. O'Malley argues, however, that despite that market decline, Māori were able to sustain relatively good incomes (O'Malley, 2019, Kindle Edition, p.867 of 3357). As the next chapter will illustrate, however, the New Zealand Wars completely decimated the economies of those directly involved in the wars. The British established a naval blockade during their war against the Kīngitanga, and so Māori shipping (canoes and schooners) in the Manukau and Waitematā stopped (Anderson et al., 2014, p.264). Meanwhile ongoing land loss, a settler dominated economy and a general downward trend of oranga heralded the demise of this post-Treaty phase of successful market participation. Te Hura and the prophets who emerged out of worn torn tribal areas in the 1850s and 1860s had many reasons to pray.

Conclusion

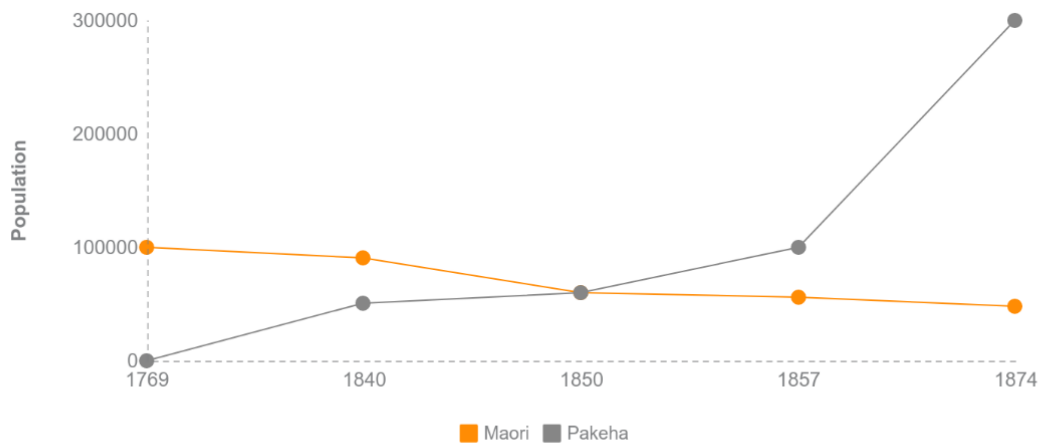
Looking back at this period it is easy to see that oranga was being eroded. The alienation of Māori land was picking up pace and tribal authority was being undermined to such an extent that outbreaks of conflict were occurring. Some Māori, in turn, looked to inter-tribal strategies to retain authority over their lands. At a macro-level, that degree of land loss tells an alarming story. At the micro-level, it is difficult to know how rangatira of hapū were coping with the loss of customary land - land that held layers of meaning and provided sustenance. It is difficult to know what it meant to lose so many people, perhaps whole whānau, in such a short time span and for reasons unknown to them. Oranga opened to Christian teachings and some western modes of living, including medicines and medical practices. The measurement of health inequities is problematic. Without natural immunity Māori were in a much more vulnerable position relative to non-Māori. That health services and medicines were used as a leverage to acquire more land is inconsistent with claims of humanitarianism, as were broken promises to establish hospitals. Even the vaccination of Māori loses its moral appeal in light of the apparent motivation to protect settlers from infected Māori.

Maori Population

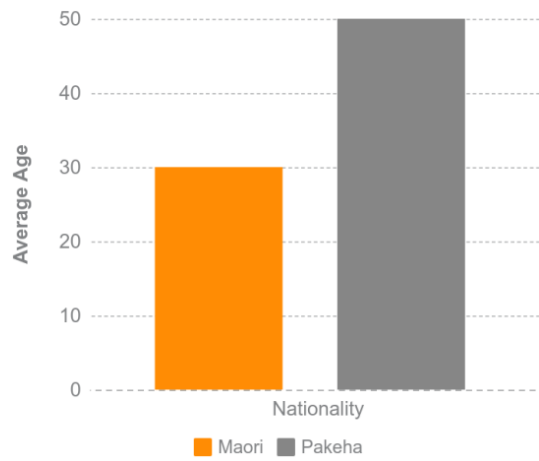


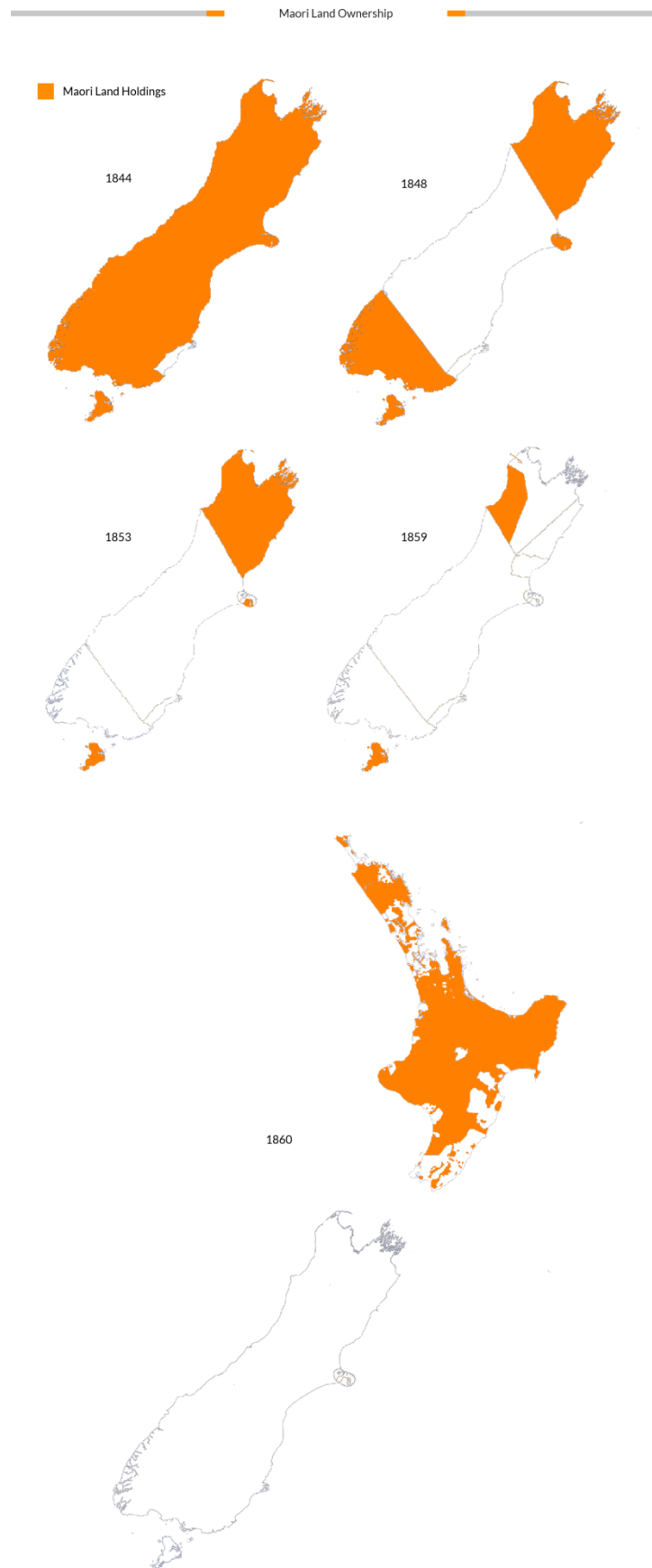
1769 (estimate)

1874



Life Expectancy





• Source: Claudia Orange, 'Treaty of Waitangi - Dishonouring the treaty - 1860 to 1880', Te Ara - the Encyclopedia of New Zealand, <http://www.TeAra.gov.nz/en/interactive/36363/maori-land-loss-south-island> (accessed 12 August 2019)

Chapter 3. Decline and Survival (1860–1900)

On 18 May 1893, Meri Te Tai Mangakahia became the first woman to address the Kotahitanga Parliament. She wanted Māori women to be given the right to vote and sit as members. Although unsuccessful, she raised a number of points to support her argument. The first two highlighted the turmoil communities were facing in the 1890s. Meri called for both a practical and symbolic acknowledgement of the contribution wāhine Māori could make to national Māori politics. Translated into English she said: ‘There are many women who have been widowed and own much land... there are many women whose fathers have died and do not have brothers’. By the end of the 19th century, Māori women were not only landowners, they were also survivors of wars, land loss and disease.¹⁰

The odds are high that the husbands and fathers that Meri Te Tai Mangakahia referred to in her address either died from diseases or the impacts of warfare - issues that dominate this period. Between 1860 and 1872, war broke out in North Taranaki, Waikato, Tauranga, Central/South Taranaki, and the East Coast/Central Plateau. This chapter explores the consequences of war on oranga Māori and beyond that the further development of health inequities. At times the two intertwine, as is the case with the introduction of Native Schools. From the Māori perspective the schools bolstered the wellbeing of whānau communities—they were places at which tamariki Māori could access education and western medicine—and were a way forward for their communities in troubling times. But from the government perspective the benefits of educating Māori and dispensing medicines through them were about assimilating Māori further into western ways of thinking and living. The chapter closes with an overview of local and national politics and the establishment of the Kotahitanga parliament at which Meri spoke in 1893. Many Māori did not survive this period, but those who did came through with a determination to shape their world in such a way that oranga might recover and thrive.

Warfare

In order to understand the impact of war on Māori during this period, it is necessary to provide a brief overview of the campaigns that occurred. The New Zealand Wars were about sovereignty and land. The government was no longer prepared to accept Māori assertions of rangatiratanga over their tribal lands and iwi Māori were no longer prepared to have the Crown encroach on their rangatiratanga. Between 1860 and 1872, wars were fought between Māori and the government throughout much of the central North Island. The wars discussed in this chapter were an extension of the wars fought in the 1840s, all of which can be collectively referred to as the New Zealand Wars (O’Malley, 2019, Kindle Edition, p.25 of 3357). In 1860 war broke out in Taranaki, followed by armed conflict in Waikato (1863–1864);

¹⁰ Bridget Williams , Charlotte Macdonald & Merimeri Penfold, 1991, p.413

Tauranga (1864); Central/South Taranaki (1864–1869); East Coast/Central Plateau (1865/1872).

War, Alliances and Strategies for Survival

War broke out in North Taranaki on 17 March 1860. The British Army attacked Te Atiawa Māori at Te Kohia Pā, near Waitara. The cause was the contestation of the sale of land at Te Kohia Pā. As the battles continued in the area, Waikato Māori entered the wars when they sent in supporters for Te Atiawa. South Taranaki iwi had also sent in support, thereby increasing the virtual spread of this war's impact in te ao Māori.

Warfare then actually entered the Waikato in 1863 when British forces crossed over Mangatawhiri stream, the aukati border of the Kīngitanga. Inter-tribal support, as occurred in Taranaki, continued in the Waikato but alliances went beyond whakapapa to include alliances based on faith. Founded by Te Ua Haumene, the Pai Mārire faith was borne out of the deep hurt caused by land loss (Anderson et al., 2014, pp.269–271) Anaru Matete, a leading chief of Ngāti Maru, explained why he converted to the Pai Mārire faith: 'We have joined the Hauhau because we think by so doing we shall save our land and the remnant of our people. We have no quarrel with the settlers' (Anderson et al., 2014, p.272) Among its converts was the Māori King (re-baptised with the name Tāwhiao), and iwi Māori from Taranaki and Whakatōhea.

Tribal support was also given to the British forces against movements that appeared to threaten tribal stability. Commonly referred to as kūpapa, they felt that good relations with the Crown was the best protection for their lands. Thus, the wars saw Māori fighting the British to defend their land and welfare, as well as Māori, including some from Ngāti Porou, fighting with the Crown against Māori for the same reason (Anderson et al., 2014, p.269).

Ngāti Porou hapū held various views of the Kīngitanga. Some supported the fighting in Waikato against the British, while others saw the Kīngitanga as a threat to their local and more traditional chieftainship. The arrival of Pai Mārire missionaries there created a schism which resulted in several months of fighting. The government was quick to send munitions and military settlers to support the Ngāti Porou faction fighting against Kīngitanga supporters and Pai Mārire converts. By October of 1865 the fighting ended with the fall of two Pai Mārire pā (Anderson et al., 2014, p.272–273).

War then spread to Tūranganui as Ngāti Porou who had converted to the Pai Mārire faith fled south. Tūranganui chiefs became increasingly concerned that the Pai Mārire presence would draw in government forces. This, in fact, did happen. In early November 1865, colonial forces and 260 Ngāti Porou under Mokena Kohere invaded the region, beginning with a siege against the pā at Waerenga-a-Hika. Over the next seven years Tūranganui was marked by skirmishing.

Meanwhile Te Kooti Arikirangi Te Tūruki, who fought with the Crown, was arrested at Waerenga-a-Hika on suspicion of being a spy. His arrest led to his imprisonment at Wharekauri Island along with those Pai Mārire captured at Waerenga-a-Hika (Anderson et al., 2014, p.274) Te Kooti emerged as a prophet and leader of the

Ringatū faith when in July 1868 he escaped aboard the *Rifleman* with nearly three hundred inmates. Colonial forces made several failed attempts to recapture Te Kooti and his Ringatū converts, but despite sporadic engagements, this mobile new religion remained elusive.

Tūhoe had themselves suffered under land confiscations (discussed shortly) and in a state of dispossession were receptive to Te Kooti's prophecies of deliverance. In March 1869 Tūhoe 'formally committed themselves and their land to him' (Anderson et al., 2014, pp.279-280). Following a battle at Ngatata, from which Te Kooti escaped, the remainder of the war years were marked by skirmishes that saw more lives lost as Crown forces and their Māori allies pursued him. In 1872 Te Kooti was offered refuge and protection in the King Country. The wars, at least in terms of physical warfare, thus ended.

The Impacts of War on Oranga

The wars had serious impacts on oranga. Aside from casualties, some Māori communities suffered extreme population declines, while almost all tribes in the North lost whenua and the resources upon which tribal economies and living relied. The political ramifications were also significant. The ability to exercise tribal rangatiratanga was severely diminished and, in turn, Māori looked to establish new or revive old cross-tribal organisations.

Population Decline

It is estimated that there were 4,250 Māori casualties during the wars. A breakdown of that figure assigns 2,000 Māori deaths to those who fought against the Crown, with 2,000 wounded. An additional 250 Māori who fought with the Crown are also thought to have died (O'Malley, 2019, Kindle Edition, p.2668 of 3357). O'Malley provides a greater insight into the actual impacts on hapū in his analysis of the casualties sustained by Tūranga Māori.

The Māori population of the Tūranga district was estimated at 1,500 in 1860, a steep decline from the 2,400 figure given in 1847. In just one week-long battle, at Waerenga-a-Hika in November 1865, at least seventy-one Māori were killed (other estimates suggested over one hundred) and an unknown number were injured In the space of a week... 4.7 per cent of Tūranga Māori died (O'Malley, 2019, Kindle Edition, p.2691 of 3357).

O'Malley goes on to show how the return of war to their rohe impacted even further on Tūranga Māori. Between 1868-9, with more casualties taken into account, 'the Waitangi Tribunal has estimated that...240 adult males were killed...[which] ..constitutes 16 per cent of the total population or an incredible 43 per cent of adult males, based on the 1860 figure' (O'Malley, 2019, Kindle Edition, p.2691 of 3357). According to O'Malley that figure does not include 'the many women and children also killed', or those who died while imprisoned. When taking into account all of those killed and wounded, he estimates a casualty rate of about 40 percent of all Tūranga Māori (O'Malley, 2019, Kindle Edition, p.2691 of 3357).

This sort of population decline would have had an unimaginable impact on oranga. The loss of human life was the loss of whānau and hapū potential, whānau and hapū

labour, whānau and hapū mana. All of this impacted on the oranga of those who survived and no doubt weighed heavily on the will of people to keep going and recover. Recovery, however, was difficult. Within war torn areas and beyond, land was confiscated by the government and by the mid-1860s, the Native Land Court was also becoming a machine of land alienation.

Land Loss—Raupatu

The New Zealand Settlements Act of December 1863 provided for the confiscation of 1.2 million acres of Waikato land. Māori who supported the Government during the wars were supposed to have been spared, but confiscation was often indiscriminate. ‘Loyalist’ Māori often received back a fraction of their original holdings or else were given lands elsewhere, and either outcome could take years to occur (Anderson et al., 2014, p.267). Many important Kīngitanga areas had been taken, leaving only the King Country. Ngāti Maniapoto provided a safe haven for many refugees from the fighting, which in turn placed huge pressures on their food sources. Conditions were cramped and unsanitary resulting in typhoid outbreaks. So many Māori had been dispossessed by the fighting and subsequent confiscations that Ngāti Maniapoto were outnumbered three to one, at least in that area recently named ‘Te Kūititanga’ (now Te Kūiti), itself a reference to the ‘narrowing in’ affect the confiscations had caused (Anderson et al., 2014, pp.267-8).

Fighting restarted in Taranaki in 1865 which led to 1.2 million acres of land being confiscated. During the fighting the homes and cultivations of Māori were targeted and destroyed. Ngāti Ruanui was especially hit hard and lost nearly all their land. Then, 1867 saw the start of that land being surveyed and allocated to settlers (Anderson et al., 2014, p.274), which sparked resistance from the prophet Riwia Titokowaru. Ongoing conflict and poverty went hand in hand.

Linking Loss of Whenua and Loss of Life

Aside from Māori population decline due to warfare, Sorrenson also raises the wider and longer-term ramifications of population decline due to land loss. He argues that population decline in the Central North Island was around the same for Māori who remained neutral or who fought with and against the Crown. In fact, he states that population decline began first for ‘friendly’ Māori in the North Island who were involved in land sales immediately after the war:

These Maoris decreased most rapidly in the eighteen-sixties and seventies. On the other hand, the defeated Maoris, who refused to sell land immediately after the wars, were spared this rapid decrease until they began to sell land in the late eighties and nineties (Sorrenson, 1956, p.184).

The loss of land, whether by raupatu or through the Native Land Court (discussed shortly), has been connected to high mortality rates for women and children, with Pool writing that ‘[t]he regions subject to early land alienation and the first New Zealand War [had] lower child-woman ratios, while the more remote parts of the North Island [had] ratios well above the national figure’ (Pool, 1991, p.90). According to Simon Chapple (in Robinson, 2011, pp.15–16), the poverty that came with land loss led to a gender disparity among Māori of 130 males to 100 females in 1857, reducing to 109 males in 1926. Robinson adds that males fared better than females in times of

hardship, which accounts for this disparity, while death in childbirth and an uneven distribution of labour may also account for a higher female death rate (Robinson, 2011, pp.15–16).

In 1896, Thos Poutawera presented on the Māori population decline at the first Te Aute Conference. Based on census returns between 1874 and 1896, he described how, in a ‘period of 22 years, no less than 5616 natives are estimated to have died, leaving none to fill their places’. His figures were based on an estimated population of 45,470 in 1874 and a population of 39,854 at the end of April 1896. That was, indeed, the year when the Māori population reached its lowest point of 42,650. The impacts on oranga were huge, as were the inequities in terms of population wellbeing relative to Pākehā. Robinson writes that ‘in Raglan...while births outnumbered deaths in the Pākehā population (in the five years to 1877) by as much as 12 to one, there were ten Māori deaths for every eight births’ (R.S. Bush, in Robinson, 17). This was, as she notes, ‘a clear signal of Māori population decline’. It was also a clear signal of health inequities.

Poverty and Oranga

The impact of the wars on hapū economies was ‘crippling and almost irreparable’, according to O’Malley, who writes that industries ‘came to a sudden and crushing end for many central North Island iwi’. Some communities had almost everything taken from them virtually overnight.’ (O’Malley, 2019, Kindle Edition, p.2716 of 3357). In turn, war impacted on oranga by severely disrupting the ability of Māori to gain sustenance and incomes from the whenua. As noted by the whaea tūpuna Ngarongo in the Kawhia district,

It stopped all our accustomed industry on the shores of the Kawhia. All the old work in which the whole of the people shared stood still. No more wheat or maize was grown, no flax scraping was done, and the trading vessels lay deserted at anchor, for there was no one to man them. The soil was not cultivated, the flourmill wheels ceased to turn. The winds wailed over a deserted Kawhia when the men, young and old, had girded themselves with the belt of war and gripped their guns and other weapons of war and marched away (Robinson, 2011, p.29).

The loss of land through raupatu also impacted on the physical wellness of Māori. Stripped of their kai and the ability to earn incomes to sustain themselves, Māori communities existed on the margins of the New Zealand economy. Their low standards of living then impacted on their health. In most Māori communities throughout this period, the lack of cash income meant that there was little possibility of using capital for sanitary works, water supplies, or housing improvements (Lange, 1999, p.28).

Large numbers of Waikato Māori moved into Te Rohe Pōtae at the conclusion of hostilities as a result of the land confiscations. This influx would have strained an already depleted resource base in Te Rohe Pōtae and may well have brought various infections into the area (Robinson, 2011, p.44).

In terms of the Waikato district, Robinson writes that war ‘was the main disruption to nutrition’. Food shortages resulted, leading to various levels of malnutrition with the associated deleterious effects on health, especially increased vulnerability to disease. The diet of Māori during that period was sourced from a combination of traditional hunting and gathering and introduced foods. Ngarongo, a prominent kuia of the area

described the waters of the Kawhia Harbour as the ‘waters of abundance’ where a variety of fish and shellfish could be caught and gathered. The ngahere too continued to be a source of nourishment as Māori maintained the practice of harvesting hinau and tawa berries, and catching birds such as the korimako, takiri and tui (Robinson, 2011, p.27).

At the same time Māori struggled with diseases, war and land dispossession, they also endured and grappled with poverty. Some tribal groups were buffered by extraction industries (gold, timber, agriculture, flax milling, near or within their tribal lands, earning meagre incomes to support subsistence living on the land. Many Māori also travelled, often seasonally, camping in makeshift camps. In the North, for example, Māori were forced to camp in swamps to make a living from gum-digging.

Pool (1991, pp.62–63) builds on Sorrenson’s argument that land purchases, confiscations, and war limited Māori access to agricultural resources, resulting in limited access to food/nutrition such that death was the result of malnutrition-infection cycles. These cycles were exacerbated by the lack of pre-European exposure of Māori to the pathogens introduced by Pākehā.

... the Māori subsistence food economy had depended on a combination of extensive and relatively intensive land utilisation. After land alienation occurred, [Māori] were restricted essentially to smaller tracts of land, and thus found it necessary to develop new strategies to obtain food and other basic needs (Pool, 1991, p.63).

Tribal Autonomy, a War Casualty

Along with population decline, land loss, and poverty, the loss of tribal authority stands out as another consequence of war. Vincent O’Malley writes that by

...1865 full responsibility for governing the colony had passed to the New Zealand Parliament, and although four Māori members were admitted after 1868, they were hugely outnumbered by the seventy-two Pākehā members. In these circumstances, the ability of Māori to influence legislation was at best limited’ (O’Malley, 2019, Kindle Edition, p.2748 of 3357).

As will be discussed at the end of this chapter, in addition to attempts to influence government policy and legislation through the system, Māori also attempted to establish a united tribal front in response to the government.

The shape of colonization had changed. While war worked at subduing Māori assertions of rangatiratanga, the Crown shifted its agenda from physical warfare to legislative warfare. Passage of the Native Lands Act 1862 and the Native School Act 1867 were to have an immediate and enduring impact on oranga Māori.

Loss of Whenua, Loss of Oranga: The Native Land Court and Land Legislation

Under the Native Land Act of 1862, the Crown’s right of pre-emption was abolished and provision was made for the establishment of the Native Land Court. Walker writes that ‘the aim of the court...was to identify the owners of tribal land and transform the communally owned land held under customary title into individual title cognisable in English law, so that Māori ownership would become ‘assimilated into

British law’ (Walker, 1990, p.135). Under the Native Land Act 1865, the Native Land Court was established, and the loss of Māori land accelerated. Settlers had long wanted the end of Crown pre-emption and the government now conceded since it believed that this would go some way to disempowering attempts by Māori to retain land collectively (Durie, 1998, p.118). For example, within three years of Ngāti Kahungunu’s Heretaunga block of 19,000 acres entering the land court system and being placed in the title of just ten trustees, 17,000 acres had been sold—often to settle debts incurred through the processes of attending and surveying lands according to Native Land Court requirements (Anderson et al., 2014, p.291).

To make matters worse, attempts to register shares in the Native Land Court system and have land surveyed was expensive for Māori communities already in state of poverty. In the 1870s Native Land Court activities were most intense in Northland and Hawke’s Bay. Whānau travelled long distances and set up camps on the outskirts of towns while court investigations (which were often adjourned repeatedly) were under way. In 1890, the Chief Judge was asked by Ngāti Whiti in Pātea to have the court moved to their settlement. It had been difficult, especially for the sick and elderly, to attend court, but the request was turned down (Anderson et al., 2014, p.293).

The 1870 Immigration and Public Works Act reversed the waiver of Crown pre-emptions (Native Land Act 1862) and soon the government was again the main purchaser of Māori land. The government could declare whole districts under Crown pre-emption, which decreased the price Māori received for land sold and prevented others from putting their land to use (Anderson et al., 2014, p.291). The next year saw the passage of the Native Land Act 1873 that ‘sought to restore a limited measure of tribal authority’ (Anderson et al., 2014, p.292). Now all owners were listed and, in theory, land could only be alienated under unanimous approval. This failed to safeguard tribal authority over land since unanimity could be artificially created by those in favour of selling land, through partitions.

In fact, the individualisation of titles under the 1873 Native Land Act further complicated (to this day) how Māori could or could not live of their lands. Māori tended to use their lands on a seasonal basis, moving between cultivations according to the seasons. By the 1870s this custom could mean losing unoccupied land that the government viewed as ‘waste land’. Also, traditionally, hapū could claim rights to land and resource usage through whakapapa, occupation, and the quality of relationships with other groups. In court hearings, however, kaikōrero began to adapt their occupation of the land and narratives to suit ownership rules favoured by the Court. In the case of Ngāti Porou, a hui was called by the veteran Rapata Wahawaha. The purpose was to encourage his kin to settle and occupy the land in the hope of attaining titles from the court (Anderson et al., 2014, p.290).

Native Schools, Western Medicine and Assimilation

While the Native Land Court undermined oranga, Native schools (introduced under the 1867 Native Schools Act 1867) reinforced the use of western health practices and medicines in Māori communities. Linda Bryder argues that Native

school teachers undertook the role of informal health workers—dispensing medicines and assisting Native district nurses (Bryder, 2015, p.90). With the wars won and the power of colonial government entrenched, assimilation policies continued along the same lines that the missionaries had sought to use mission schools as a means of teaching Māori to ‘civilize, convert and colonize’ them (Rountree, 1998, p.49).

Ranginui Walker writes that Governor Grey’s Education Ordinance of 1847 ‘subsidised church boarding schools with a view to isolating Māori children from the “demoralising influence” of their villages. Funding was conditional upon schools instructing Māori children in English. The aim was to assimilate Māori as quickly as possible into European ways’ (Walker, 2016, p.23). The Native Schools Act 1858 reinforced the 1847 Act when it extended funding to Māori boarding schools. Schools that failed to inculcate government assimilationist aims were severely criticised. In 1867 it was reported that 13 Native Schools were ‘failing to eliminate “Māori communism” and ...emphasising religious instruction ahead of other subjects’ (Walker, 2016, p.23).

The government took greater control of the education of Māori children under the Native Schools Act 1867. This act provided for the establishment of primary schools in Māori communities who requested and provided the land for them. The Department of Native Affairs oversaw the schools and set the curriculum. Walker writes that ‘the genealogy of Māori knowledge was excluded and disqualified as inadequate’ and ‘despite elimination of their own culture from the curriculum, Māori leaders supported the Native School system in the hope that their children would gain access to the benefits of the New World’ (Walker, 2016, pp.23-24).

Within this assimilationist agenda, Native Schools also played an important role in communicating information about hygiene and sanitation. By 1900 85 had been established and were especially common in Northland, the Bay of Plenty and the East Coast (Anderson et al., 2014, p.323). Initially these were built mostly in areas where Māori had supported the Crown during the land wars. These were financed in part by taking from funds for church boarding schools, however Māori did view these as institutions that were their own. This seems to be true despite the clear assimilationist goals the government had for them (Anderson et al., 2014, p.294).

In 1884, James Pope, the Inspector-General of Schools (1884–1903) wrote ‘Te Ora mō te Māori’ as a response to the shortage of doctors and the consequent dependence upon Native School teachers as dispensers of medicines to Māori communities (Dow, 1999, p.89). That same year, Pope (1884, p.82) even advised communities ‘[i]f you cannot get a doctor, the next best thing is to go for advice to a magistrate, or a teacher, or a minister’. Pope led out the charge of Inspectors endorsing the delivery of healthcare to Māori this way, and was followed in this by his successors William Bird, John Porteous and D.G. Ball.

The Native Department supplied Native school teachers with medicines (e.g. castor oil, chlorodyne, sulphur ointment, quinine) so that they could deliver health care. However, their task was often complicated by their lack of medical knowledge—although Pope claimed that ‘very little health knowledge’ was required (Dow, 1999, p.89)—and community resistance to teachers giving their children medicine. These

were key reasons for Pope publishing ‘Te Ora mō te Māori/Health for the Māori’ as a health manual for use in Native Schools. Its publication in both English and te reo Māori was in an effort to make Pope’s ‘laws of health’ widely available, because of his belief that Native Schools were an ideal place to deliver the ‘common sense’ of health to Māori. Unsurprisingly, the writing in his book was both simplistic and paternalistic as he condemned the bad habits Māori had for ‘communal living’ and cultural practices such as tangihanga (Simon et al., 1998, p.122).

Pope also had a penchant for criticizing the gullibility of Māori, who he saw as being taken in by Māori ‘prophets and doctors’ who he considered charlatans. In 1884 he wrote in his report on the Matakohe Native School that,

The [school] master evidently does his best to get his pupils on, and it is to be regretted that he has not a more favourable field to labour in. Where he is, his efforts are, to a large extent, wasted. There had been serious disagreements amongst the Natives, and they had also been troubled with one of those prophets and doctors that crop up from time to time in Māori settlements, and set everything awry, including the school (AJHR, 1884, E-2, p.6).

Infectious disease was one of the reasons why Native Schools experienced low student numbers that forced them to close at times. ‘Epidemic fevers’ in 1886, for example, affected Waipatu, Whangape and Kaikohe, and several schools were affected sickening (Simon & Smith, 2001, p.217). Teachers often wrote to the Inspector-General of Schools to explain their actions, as Agnes Grant did in 1898.

...last week the epidemic took a much more serious form and several of the children had bad relapses and we were all busy from morning to night nursing them. No less than seven of them had temperatures of 105 & three nearly reached 106. Already fifteen of the children have either had the measles or are ill with it at present & three more are apparently sickening (Simon & Smith, 2001, pp.217-218).

At other times, teachers turned their classrooms into temporary health care facilities for communities hit by epidemics, in spite of explicit instruction that the school was only to be used as a school room sickening. Younger children in particular benefitted from the care they received, and their successful recovery was used to reinforce the value of western health knowledge (Simon & Smith, 2001, p. 218). At the same time, the reasons for these epidemics continued to be placed at the feet of Māori. Pope, for example, wrote of ‘Native ignorance and neglect of sanitary laws’, ‘Native improvidence’, and the effects of alcohol consumption (AJHR, 1884, E-2, p.6; also in Simon & Smith, 2001, p.225). By contrast, Native school teachers among other Pākehā authority figures were seen as having a positive influence of the health habits of their communities.

... the efforts of the Resident Magistrates, of Native school teachers, of clergymen, and of philanthropic Europeans generally, are in many districts overcoming, to some small extent at all events, the bad influences that tend to keep the Maoris down and to lead to their extermination. In those districts, though, where there are few or none of these counteracting beneficial influences the Maoris are slowly but very surely dying out (quoted in Simon & Smith, 2001, p. 225).

Māori had always shown a keen interest in literacy and international trade to facilitate engagement with the modern world and enhance oranga and mana. This continued. However, the power balance was shifting toward a tipping point whereby Māori

values, language, customs were set to be overwhelmed by the constant reinforcement of western education and the values contained within it. The content of native school education was not intended to be complementary to Māori ways of knowing; it was intended to replace it. In principle then, the acquisition of literacy by Māori students from western instructors, or Māori receiving hospital care is not in itself the issue. It is the colonising context that it was occurring within. As with the native school teachers, the health education that district health nurses and native medical officers provided was not intended to compliment Māori understandings of oranga, but to replace it. Quite aside from the specifics of teaching geography or arithmetic, native school education openly sought to dislodge the remaining determinants of oranga: whānau and whakapapa.

Infectious Diseases, Vaccination and Māori Perceptions of Western Medicine

Infectious diseases continued to impact on Māori throughout the mid and late nineteenth century and health policy during this period was mostly reactionary to that. State assistance was minimal, and though Māori health was targeted through subsidized medical officers, public money was for the most part applied to hospitals. In the decades after 1870 ‘the hospital sector became increasingly directed towards European needs, with provision for Māori varying greatly between localities’ (Dow, 1999, p.57). In this period the control of hospitals began shifting from the provinces back to central government. What focus there had been on Māori health became further diluted as the European population expanded (Dow, 1999, p.61). In 1876, Resident Magistrate R.W. Woon described how Māori were ‘practically shut out of the Wanganui Hospital, an institution originally endowed and set apart for their special benefit’. Instead it seems that Māori there were accessing medicine from supplies given to Native School teachers by the Native Department (Dow, 1999, p.66).

Since the 1852 New Zealand Constitution Act (discussed in the previous chapter), the onus of Māori health lay with the provinces (Dow, 1999, p.33). Then in 1861 Governor George Grey created a ‘Plan of Native Government’, dividing the North Island fees. These medical professionals, known as Native Medical Officers (NMO). NMOs, were a group that was inconsistently funded and staffed around the country (Robinson, 2011, pp.52–53). Grey’s plan became known to Māori, many of whom now expected doctors to be stationed around the country (Dow, 1999, p.40). Funds targeted at Māori health would often be split between subsidies for the NMOs and supplies of medicine (Robinson, 2011, pp.51–52). Often though, medical services outside of hospitals required the payment of fees. By 1866 an estimated 20 percent (approximately 35) of the colony’s doctors held paid appointments to provide care for Māori (Dow, 1999, p.46). However, the relatively small sums paid to NMOs shows that their attendance to Māori was only a small part of their practice (Robinson, 2011, p.54).

Continued outbreaks of infectious disease saw the passage of the Vaccination Act(s) of 1863 and 1871. Then in 1872 the Public Health Act was passed, which would emphasise the use of vaccination and improvements in sanitation to combat the spread of disease (Dow, 1999, p.92). Smallpox could be vaccinated against, while

typhoid required sanitary improvements. These legislative changes allowed provinces to appoint medical officers as vaccinators for each district, though this formalised what had already begun amongst Māori after the creation of The Central Board of Vaccination for the Aborigines of New Zealand in 1854 (Dow, 1999, pp.53–54). Arthur Thomson, an original member of the board claimed in 1859 that two-thirds of Māori had been vaccinated for smallpox, although evidence of this or of the effectiveness of the board is not available (Dow, 1999, p.52).

In 1873 a looming smallpox outbreak revealed bureaucratic inefficiencies for administering vaccines. The Resident Magistrate for Ōpotiki Herbert Brabant reported that Māori there were happy recipients of medical care, though at the same time Urewera Māori were not able to be vaccinated due to low supplies (Dow, 1999, p.55). In 1862 the Resident Magistrate of Wairoa reported that Māori would often exaggerate their numbers as a way of securing more medical aid (Dow, 1999, p.43). The ‘scattered nature’ of Māori settlements also meant difficulty in gathering Māori in one place. Compounding this was insufficient funding for vaccinators to travel to Māori communities. By 1884 an estimated 7,300 Māori were vaccinated against smallpox, out of a population of 45,000 (Dow, 1999, p.85).

Post-War Māori Views of and Access to Pākehā Medicine

Māori reaction to western medicine and doctors varied after the wars and could range from engagement to indifference. In 1882, the Inspector General of Hospitals reported that less than one percent of people treated in Wellington Hospital were Māori (Dow, 1999, p.69). Buck and his fellow medical student Dr Tutere Wi Repa expressed frustration at Māori being overly suspicious about hospitals. It appears that the ‘reluctance to admit Māori [to hospitals] was matched in some instances by Māori reluctance to be admitted’ (Dow, 1999, p.108).

Māori of the Kīngitanga movement were especially distrustful of Pākehā doctors who were seen as Crown agents. In 1873 a vaccination campaign in Raglan saw the District Medical Officer refused permission to cross the aukati to vaccinate King Country Māori. The account given by William Mair was that ‘Hauhau’ Māori perceived the request as a ploy by the government to enter their region. Over time though suspicion faded and Māori within Te Rohe Pōtae engaged more with doctors. Overall, Robinson argues that the political fallout from wars fought were the main reason for Māori mistrust of doctors rather than any deeper rejection of western medicine (Robinson, 2011, pp.56–57).

In 1884 the MHR for Southern Māori H.K. Taiaroa argued in parliament that Māori understood and wanted vaccination. Yet the next year Dr Matthew Scott, stationed on the East Coast to administer smallpox vaccinations, reported that ‘religious prejudice’ on the part of Māori prevented the success of the programme (Dow, 1999, p.85). In 1880, three hundred and thirty Māori of a population of seven hundred were vaccinated in Wairarapa during a looming smallpox outbreak, though officials there and in Thames noted ‘great difficulty’ in persuading Māori to do so (Dow, 1999, p.85). This apparent resistance existed in contrast to the South Island, where Māori ‘of their own free will... have been vaccinated’ (Dow, 1999, pp.84–85).

Accessing medical care during this period often proved difficult and sometimes impossible for Māori communities. For instance, by 1870 the nearest registered medical practitioners for Rohe Pōtae Māori were in Hamilton, Ngāruawāhia and Raglan. When the NMO in Raglan retired, his replacement T.B. Hill was not installed for another decade. By 1889 the situation had not improved, with only three NMOs in Hamilton and one in Cambridge (Robinson, 2011, p.54). During fighting in 1863 militia hospitals were established at Cambridge and Hamilton, although these provided basic medical care only, and were disestablished anyway when government troops were withdrawn. So even when the militia hospitals were operating, those in need of more advanced care had to journey over 150kms over poor roads to the Auckland Hospital. Otherwise there was the hospital in Ngāruawāhia, built in 1875, though closed in the same year due to a lack of funds.

Over time the Pākehā settlement in the Waikato expanded as the main trunk railway line was being completed. The demand for a hospital increased with this and in 1887 the Waikato Hospital was built in Hamilton (Robinson, 2011, p.59). Accessing this hospital though was hard, even with the completion of the main trunk rail line, as even getting to the rail line required difficult overland travel since there were no formed roads in Te Rohe Pōtae south of Otorohanga (Robinson, 2011, p.61).

Te Rohe Pōtae was rather a unique case during the later decades of this period. Māori there had banned Crown agents from the inquiry district for nearly two decades as a result of wars fought in and around Waikato (Robinson, 2011, pp.47–48). They were therefore compelled to travel outside the district when comprehensive medical care was needed. The dearth of doctors and hospitals were matched by the lack of roads to access what health care was available, although this was partly alleviated by the main railway line built through the area (Robinson, 2011, p.50).

The use of colonization as an explanatory device makes little sense when viewing Māori health policy in isolation. This view would result in a much gentler appraisal of the history of Māori health policy; namely that the majority of the problems of the health system as it progressed historically in New Zealand could be attributed to circumstance—a cash-strapped nation-state barely into its adolescence finding its feet and generally doing its best to provide equal health care to Māori and Pākehā alike. Under this interpretation, health inequalities merely represent the natural difficulties inherent in service delivery by a European style nation-state to a culturally distinct and tribally diverse populous who for the most part did not live in towns where most health care was based. For example, Robinson argues that the state in the nineteenth century was not in a position to do more as it was not understood how diseases were spread and the state lacked funds and infrastructure to deliver health care. Robinson then argues that even if there had been a comprehensive state health care service provided to Rohe Pōtae Māori at this time, it is unlikely that it would have significantly alleviated their health problems (Robinson, 2011, p.63). Robinson argues that an appropriate framework for assessing health policy and Māori is to take the indices of western health as they existed for Pākehā at a given period as a measure of what was possible to achieve at that time. The argument though, can be extended in different directions and used to ask for instance, if it was possible in the 1860s to field

an army of 18,000 soldiers, was it not also possible to field a likewise army of doctors and nurses, even if to smooth the pillow of an apparently dying race?

Consolidation of Rangatiratanga and the Struggle for Survival

Māori reacted swiftly as the welfare of Māori communities became urgent and leaders diversified in their political attempts to address the toll of colonization on oranga. The establishment of the Kīngitanga, the passive resistance of Tohu Kakahi and Te Whiti-o-Rongomai at Parihaka, the Repudiation movement and Kotahitanga (Māori Parliament) all speak to expressions of rangatiratanga, and the centrality of the whenua, whānau and whakapapa to the wellbeing of iwi Māori communities.

Boundaries and Settlements

The Kingitanga, Parihaka and within Tūhoe, established aukati (boundaries) to protect against the entry of unwanted settlers and the Native Land Courts. However, the relative strictness or leniency of these boundaries would shift to improve the wellbeing of communities. As the construction of rail lines approached them, for example, Ngāti Maniapoto leaders opened the aukati to enable themselves to engage ‘with the surrounding districts’ (Anderson et al., 2014, p.303). In 1881, Tawhiao crossed the Kingitanga aukati for the first time following the wars to lay down his arms at the feet of Resident Magistrate William Mair. Tawhiao attempted (unsuccessfully) to use petitions and political negotiation to seek the return of whenua and to alleviate the poverty of his people (Anderson et al., 2014, pp.303–304). Tūhoe banned outright any Native Land Court encroachment on their whenua yet sought unsuccessfully to have roads constructed to connect their communities to the main highways. At the heart of these aukati was a desire to stem the loss of land and to raise communities up above the poverty in which they lived.

Parihaka and Te Whiti and Tohu

Tohu Kakahi and Te Whiti-o-Rongomai preached a message of deliverance and the restoration of rangatiratanga. They peacefully challenged the government’s land confiscations in Taranaki, mounting a campaign of passive resistance in 1878. The community of Parihaka, with around 300 members, was settled on confiscated land which the government began surveying that year (Anderson et al., 2014, p.297). Survey pegs were continually removed, fences were continually constructed to block roads into the community, and surveyed lands were ploughed for gardens. All the while Parihaka men were arrested and imprisoned. By 1881 the population of Parihaka had expanded to over 1,300, one of the largest Māori and progressive communities in the country (Anderson et al., 2014, p.298). The Crown’s response to the campaign of resistance led to the arrest and imprisonment of more than 400 men between 1879 and 1880, and in 1881 a force of 1,600 police and militia violently invaded Parihaka (Anderson et al., 2014, p.299). Homes were destroyed, people were ejected from the whenua and the community leaders and many others were imprisoned without trial.

Oranga, Trauma and Whakamā

No words can adequately express the trauma that occurred at Parihaka, or the trauma of the New Zealand wars, or the trauma of land loss and poverty that Māori lived through in the latter half of the nineteenth century. How that trauma manifested then and into the future—intergenerationally—is a huge issue for Māori today.

Rachel Buchanan, a descendant of Parihaka tupuna, talks about the complex issues raised by Crown apologies for past wrongs, and how the apologies themselves brought more pain and anger rather than a sense of reconciliation for Taranaki descendants. She also talks about whakamā, a deep Māori sense of shame that is ‘both a state of mind and a behaviour associated with particular situations and causes’. Joan Metge defines whakamā as: ‘shyness, shame not only for wrongdoing but also for being suspected of it, embarrassment over falling short in some respect, feelings of injustice, powerlessness and frustration’. The common denominator, according to Buchanan, is ‘feeling at a disadvantage, being in a lower position morally or socially whether as a result of your own actions or anothers’ (Buchanan, 2012, pp.66-67).

It is argued that Māori held this deep sense of whakamā in the late nineteenth century, and that whakamā was transferred intergenerationally. The trauma originated within a colonising environment most keenly felt and easily identifiable in the late nineteenth century. War and the confiscations of whenua that followed, left many Māori people in tragic circumstances. O’Malley (2019, Kindle Edition, p.2716 of 3357) writes,

An official return published in 1900, which identified Māori rendered landless as a result of confiscations, listed thousands of individual names. Behind each name there lay a story of dispossession and sometimes exile that was likely to have resonated over many generations. The New Zealand Wars touched the living, along with those yet to be born. These policies were felt by Māori throughout the country, whether or not they had taken part in the wars.

Buchanan writes that one way in which people responded to whakamā was by forgetting shameful events. She refers to the work of Alexis Wright, a member of the Waanyi nation in Australia, who writes: ‘many families have stories that are impossible to resolve. The stories in these families ..created a sense of shame or humiliation, and are hidden or destroyed’ (Buchanan, 2012, p.67). Buchanan also notes that ‘for people who have been colonised, there are many shades of whakamā’. The state of whakamā could exist individually, as a whānau or as an iwi, and might include ‘shame about the loss of language and land and about the loss of resources, traditions and leaders’ (Buchanan, 2012, p.66).

This shame or humiliation and need to ‘forget’ is often associated with the passage of time but given the realities Māori were living at the time, one would understand how the need to forget would have been an immediate response in order to survive and carry on.

Living to Survive

Lange writes that Māori communal life was still a strong feature of the way people lived in the later decades of the nineteenth century (Lange, 1999, p.20). Māori mostly lived in rural villages/kāinga, with other seasonal, makeshift camps used for activities

away from the kāinga (e.g., shearing, gum digging). However, the kāinga became more and more permanent locations as Māori felt the pressure of land loss. The location of some kāinga impacted on the health of residents, as did the construction of their homes from traditional materials. Robinson found that Māori homes lacked the ‘central measures for housing conducive to good health - clean water supplies, appropriate toileting arrangements and food storage facilities and a good source of heat. Instead, housing tended to be ‘hot, stuffy and crowded’, with Te Rangi Hīroa (Peter Buck) commenting on the frequency of Māori experiencing ‘near-asphyxiation’ due to the fires burning within wharepuni often having no means for smoke to escape (Robinson, 2011, p.39).

Even in the absence of burning fires, ventilation was poor and facilitated the spread of tuberculosis, made still worse through dampness that exacerbated influenza and asthma (Robinson, 2011, p.40). For the majority of the nineteenth century housing was not considered a state responsibility, though this would change in the 1880s as Pākehā working class housing issues became politicized (Robinson, 2011, p.42).

As noted above, nutrition was also poor. Much environmental damage had been caused through settlers adapting the land. The draining of lakes and swamps imposed on the ability of Māori to access eel and other food resources; similarly with the clearing of forest areas birdlife was also diminished. Access to these resources were not only important for day to day sustenance, but also for the ability of Māori to provide manaaki to manuhiri - one of the most important ways for hapū to demonstrate that it had mana (Anderson et al., 2014, p.315). By limiting access to traditional foods, the mana of hapū and by extension its oranga were also infringed upon.

With people staying in close proximity to one another, infections easily spread most notably at hui and at tangihanga, when large numbers of people stayed together in ill-ventilated whare for anywhere from several days to many months. Sometimes the tūpāpaku also travelled from place to place before it reached its final burial site. A 1900s case noted in Lange (1999, pp.27–28) was of a three place, five-month journey of someone who had died of typhoid.

The mobility of diseases was also helped by the dependence of Māori on seasonal work like gum digging, road works and railway building. Native Land Court hearings often took place far from Māori attendees and so this too necessitated lengthy travel from home. One hearing sat for four months during an especially rough winter in 1887. Ninety percent of Māori attendees lived in tents during the hearing (Robinson, 2011, p.41).

Māori expressed the difficulties they were facing in their communities in letters to state officials and newspapers. They detailed ‘recurring struggles...over the sale, rent and illegal taking and use of land, and difficulties resulting from the Native Land Court sittings. They also [documented] social problems arising ... from hunger, debts and issues with alcohol’ (Anderson, et al., 2014, p.293). On 22 September 1870, William Marsh Te Rangikaheke wrote about the lack of food at Ōhiwa, and how the people were hungry, poor and falling into debt due to the need to buy potatoes. A letter from W. H. protested what he believed was an illegal practice of being paid for land with liquor (Anderson, et al., 2014, p.293).

Tribal Authority and Unity

As fighting died down in the early 1870s, Māori became increasingly adept at working within systems of parliament ‘and used the courts, petitions and protests, and parliamentary representatives to advance their causes’ (Anderson et al., 2014, p.294). Through the courts Māori gave voice to a variety of grievances. Many cases were lost although Ngāi Tahu was able to receive £10,000 after it litigated against the Otago provincial government after land reserved to Ngāi Tahu under Governor Grey in 1853 failed to be created (Anderson et al., 2014, p.293).

Many Māori leaders were also influential where local administration was concerned. The Resident Magistrates Act 1867 retained Māori assessors who worked with rural magistrates. Paid Māori police were also retained. Rangatira were able to get themselves appointed to local Licensing Courts which gave them a way of addressing the problem of alcoholism (Anderson et al., 2014, pp.294–295). Tūhourangi were able to build up their economy by establishing a successful business guiding tourists through the Pink and White Terraces, although this halted dramatically in 1886 when Mt Tarawera erupted destroying the Terraces and a near-by village (Anderson et al., 2014, pp.313–314). More than one hundred and fifty people died, and most were Māori. The survivors re-established their tourist business though this time in Whakarewarewa. This was staffed entirely by the women since the men worked away.

Kohimarama Conference

The Treaty of Waitangi was a focus behind the drive for Māori autonomy. Three hundred Māori attended the 1879 Kohimarama conference and decided to meet regularly where the Treaty had been signed, at Waitangi. The first of these hui was in 1881. Their ‘most significant demand was... for a form of Māori authority’, as in Pan-Māori authority (Anderson et al., 2014, p.308). In 1879 a collective of nine chiefs from Ngāi Tahu, Ngāpuhi, and the areas between, issued a demand to the government that a Māori parliament be established and vested with rights of veto over all matters that concerned Māori (Anderson et al., 2014, pp.309–310). In 1882 the Ngāpuhi chief Hirini Taiwhānga travelled to England to meet with the Queen. Like Tāwhiao he wanted to draw her attention to the injustice of the land wars, the subsequent confiscations and the lack of a Māori authority to check the settler government. Like, Tāwhiao, he was discredited by the New Zealand government and so was not able to meet with the Queen (Anderson et al., 2014, p.310).

The Repudiation Movement

The loss of land through the Native Land Court led to the establishment of the Repudiation Movement. Led by Henare Matua and Wi Pere, the movement encouraged hapū to place their land within trusts to protect them against title individualisation. Without any legal standing, however, Pere then established the New Zealand Native Land Settlement Company, into which lands could be vested for development in return for shares and Pākehā could invest capital. The venture failed, though, as its inception coincided with the economic depression of the 1880s.

Henare continued to facilitate meetings where rangatira would discuss tribal unity as a way to reverse the land confiscations. Similar discussions were held in various parts of

the country and in 1872 Tūhoe created the Union of Mataatua. Under this, a council called Te Whitu Tekau (The Seventy) was set up which sought official recognition, though this was not forthcoming (Anderson et al., 2014, p.307). In Rotorua the Tūhourangi tribe established the Pūtāiki, a group that aimed to prevent unauthorised surveys and land negotiations. Ngāti Whakaue and others of Te Arawa created Te Kōmiti Nui o Rotorua. In 1879 the Kohimarama conference was re-convened by the chief Paora Tuhaere (Anderson et al., 2014, p.308).

Te Kauhaunganui was established under the mana of the Kīngitanga, which in April 1894 promulgated its own constitution, establishing a two-tiered house of assembly consisting of manukura (high chiefs) and matariki (commoners). Meetings took place annually to advise the King on policy, along with an executive headed by the tumuaki, Tupu Taingakawa. Te Kauhaunganui convened regularly until the 1920s.

The loss of land and authority brought rangatira together through the 1880s and 1890s, and by 1892 their unity was expressed in Te Kotahitanga o Te Tiriti o Waitangi - the Māori Parliament. Most, but not all iwi, joined in their focus toward Te Tiriti o Waitangi to recover their loss of land and authority. All of those present knew how important it was to the wellbeing of their people that they take a stand. Māori women were also active, such as Meri Te Tai Mangakahia who stood before the Parliament in 1893. It was hoped that the Māori parliament would take its place alongside the government as the authoritative body over Māori affairs. However, it was never acknowledged by the government as such.

Vincent O'Malley quite rightly argues that the government and settler population were in no position to make any concessions or even pay lip-service to the notion of equality during this period. He writes,

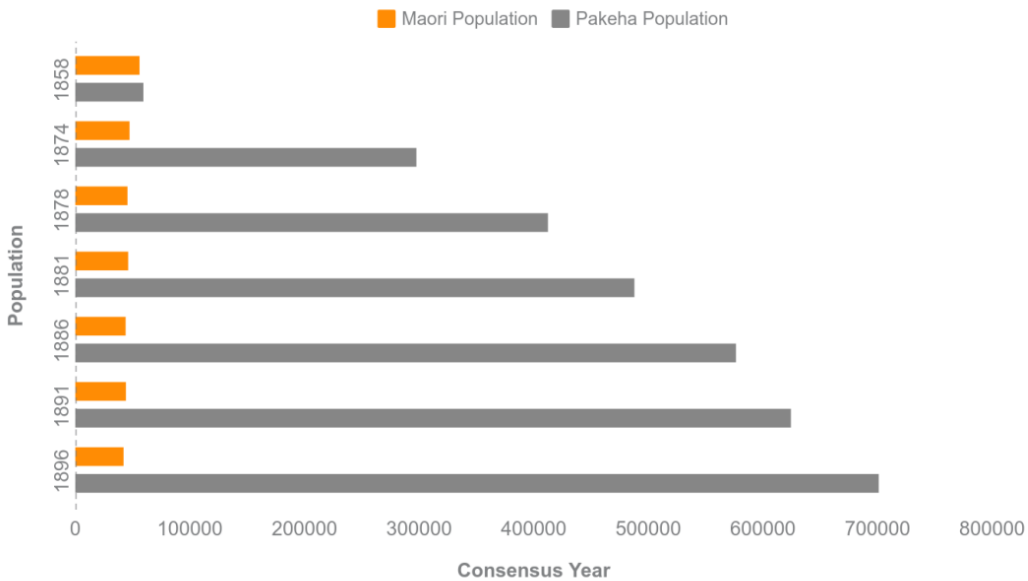
The rough-and-ready balance of power between Māori and Pākehā, which had existed since before the Treaty was even signed in 1840, finally came to an end. Pākehā were no longer required to treat Māori as their equals. With their long-standing expectations of racial dominance, settlers were moreover unwilling to share power with Māori communities. Instead, it was to be exercised for the benefit of Pākehā. Not until the 1970s did this situation begin to change in any meaningful way (O'Malley, 2019, Kindle Edition, p.2748 of 3357).

Conclusion

The immediate effects of war were devastating on Māori communities. Even before physical warfare ceased, legislative warfare was enabling the alienation of Māori land. Tribal communities lost people, land and control over their lives. In the meantime, infectious diseases continued to ravage communities. The Māori population hit rock bottom in 1896, with only 42,650 men, women and children. Māori battled to retain their residual land holdings and leaders diversified in their political attempts to address the toll of colonization on oranga during this period. However, the government had little reason to negotiate anything with Māori by this time. The chapter argues that the concept of whakamā best describes how the trauma of colonization manifested and was expressed during this period. It encapsulates the subtle shades of shame, anxiety, humiliation and powerlessness that would have sat alongside pure anger and terror. It

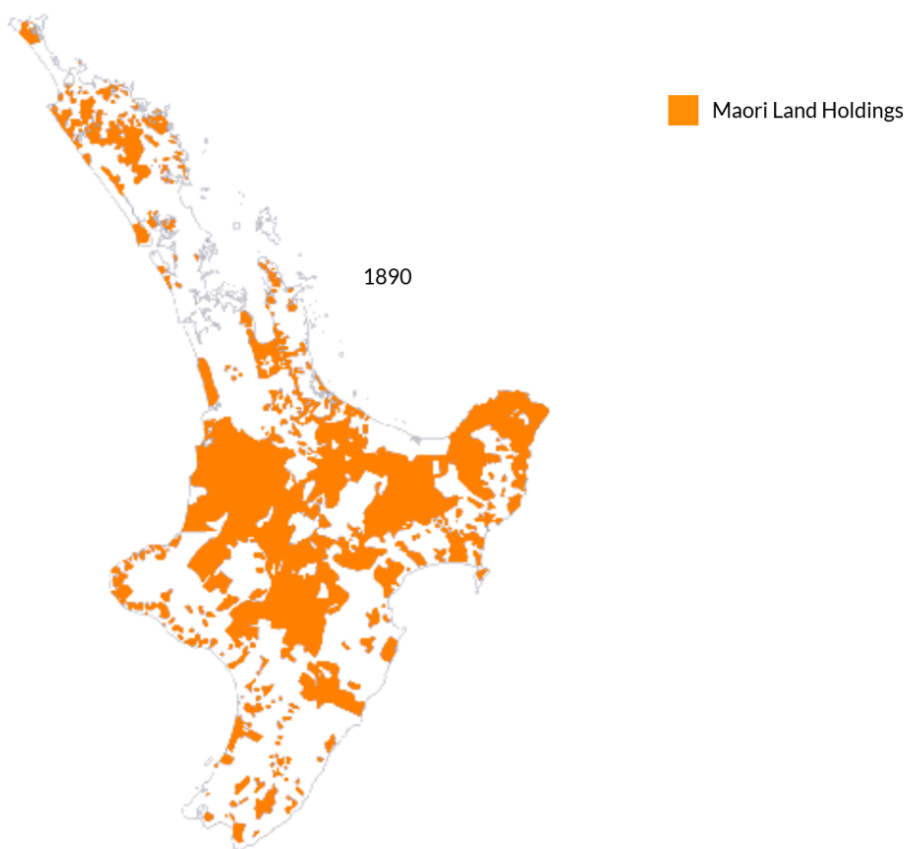
also suggested that this was a time when Māori chose to ‘forget’ (not permanently), but place toward the back of one’s mind, the trauma of that time. Life had to go on.

New Zealand Population

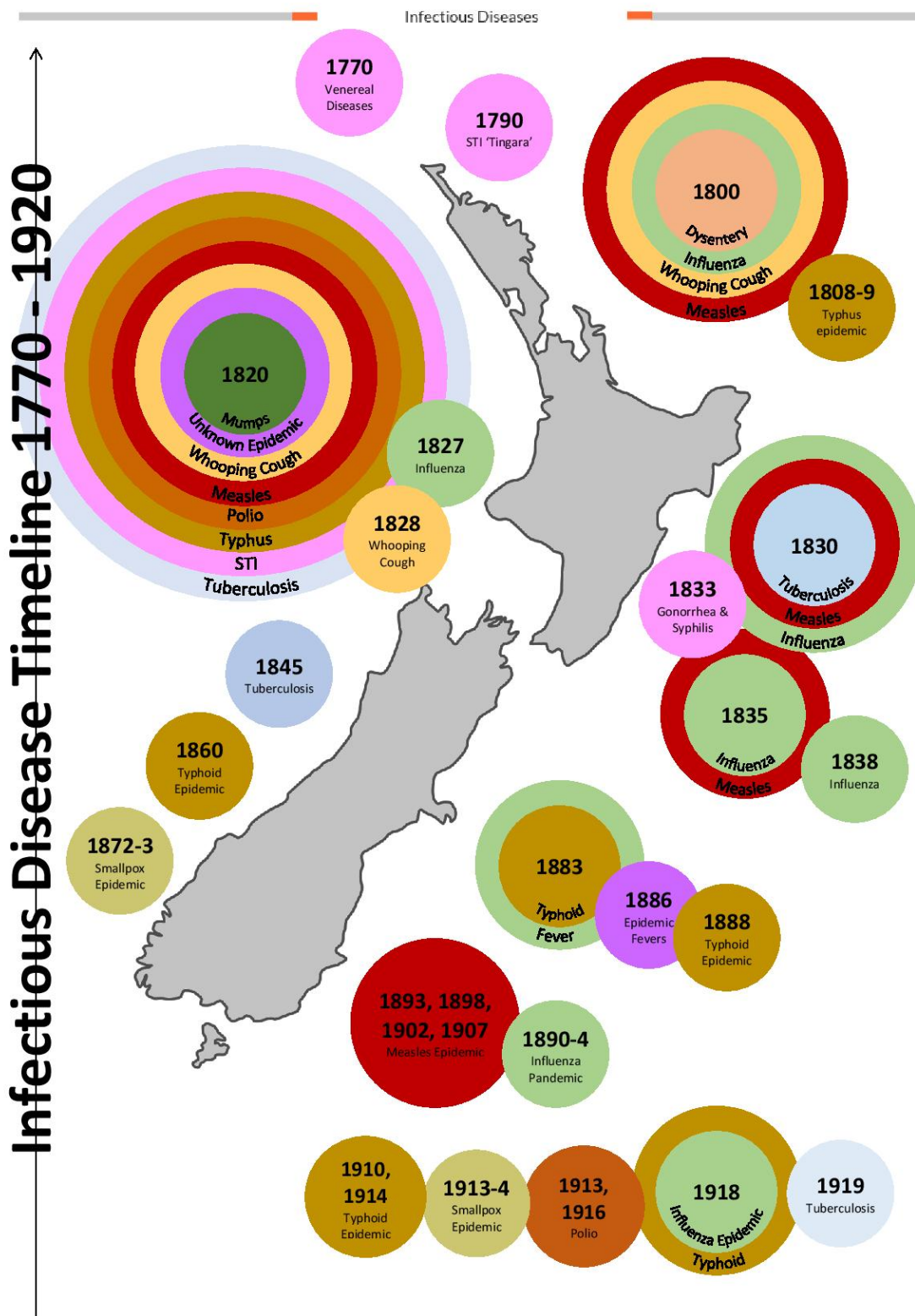


NZ Population 1858-1896

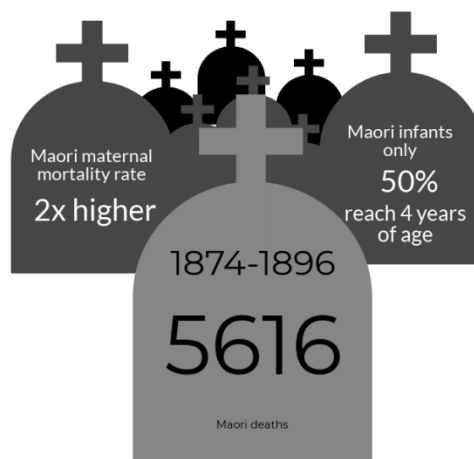
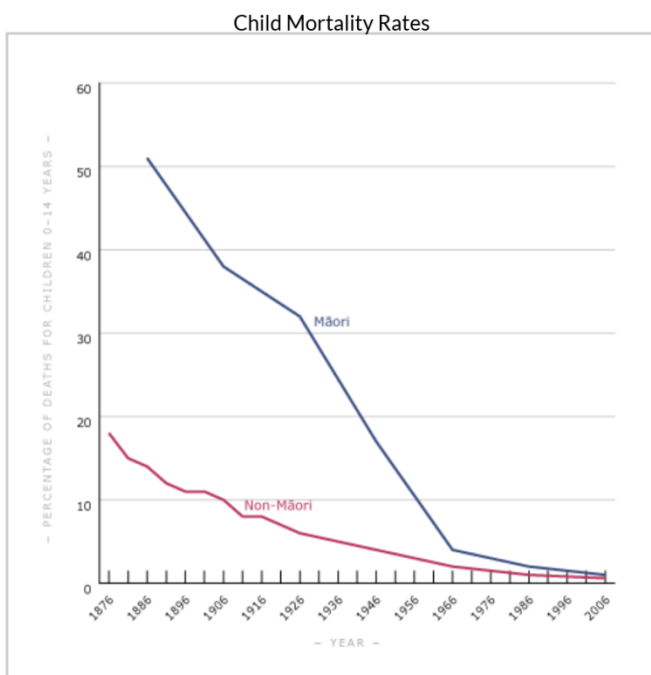
Maori Land Ownership



- Source: Jim McAloon, 'Land ownership - Māori and land ownership', Te Ara - the Encyclopedia of New Zealand, <http://www.TeAra.govt.nz/en/map/17888/maori-land-in-the-north-island-1860-1939> (accessed 12 August 2019)
- Claudia Orange, 'Treaty of Waitangi - Dishonouring the treaty - 1860 to 1880', Te Ara - the Encyclopedia of New Zealand, <http://www.TeAra.govt.nz/en/interactive/36363/maori-land-loss-south-island> (accessed 12 August 2019)



Mortality Rates



- Source: Ian Pool and Rosemary Du Plessis, 'Families: a history - Late 19th and early 20th century families', Te Ara - the Encyclopedia of New Zealand, <http://www.TeAra.govt.nz/en/graph/30198/maori-and-non-maori-child-mortality-rates> (accessed 16 August 2019)
- Source: Jim McAloon, 'Land ownership - Māori and land ownership', Te Ara - the Encyclopedia of New Zealand, <http://www.TeAra.govt.nz/en/map/17888/maori-land-in-the-north-island-1860-1939> (accessed 12 August 2019)
- Claudia Orange, 'Treaty of Waitangi - Dishonouring the treaty - 1860 to 1880', Te Ara - the Encyclopedia of New Zealand, <http://www.TeAra.govt.nz/en/interactive/36363/maori-land-loss-south-island> (accessed 12 August 2019)

Chapter 4. He Aha te Mate? The Scars of Recovery (1900–1945)

On 20 February 1905, Wahine Toa was admitted to Auckland Asylum for the second time. Little more than a month earlier she had been discharged after a six-month stay. Her return was not voluntary. Prior to her admission Wahine Toa was arrested on the Auckland Wharf for ‘dangerous behaviour’. While going to catch a steamer she had ‘struck several persons’ and ‘used bad language’. Upon her admission, Wahine Toa was described as being of ‘good’ ‘bodily condition’. She was only 40 years old, married, and her ‘form of mental disease’ was recorded as ‘acute mania’. Wahine Toa spoke only in Māori and, according to the hospital’s interpreter, was ‘shouting prayers’. Doctor Walker noted that he could not ‘get any rational conversation with her, that she was violent. Her husband, who accompanied her to the hospital, informed the doctor, probably also through the interpreter, that the ‘exciting cause’ for his wife’s condition was a ‘dispute about land’. Her husband explained that their son had recently died at the age of twelve years. The cause of her insanity was determined to be unknown.¹¹

Wahine Toa introduces the theme of mental health to this report, a theme that will be followed up later in this chapter and again in chapter six. Whether she had ‘acute mania’ or not is somewhat beside the point. Anyone thought to be a danger to the public back then could find themselves in an asylum. But something was very wrong in Wāhine Toa’s world. The previous chapter illustrated how poverty and land loss shaped the lives of Māori when Wahine Toa was admitted to the asylum. She would have been born into and raised in such conditions. This chapter highlights some of the challenges Wāhine Toa and many other Māori were forced to deal with at the beginning of the twentieth century: the ongoing loss of land and the loss of tamariki. The ability to exercise tino rangatiratanga, severely curtailed by the wars, saw Māori increasingly work ‘within the system’ to gain some degree of autonomy to address the wellbeing of their communities.

The development of population immunity to some infectious diseases and the increasing availability of vaccination should have challenged misconceptions about Māori being to blame for their poor health. However, racism remained firmly in place in Pākehā attitudes towards Māori, as will be seen in the Plunket Society and the delivery of social welfare and state housing. It was racism that also pushed Māori into low paid employment and denied infrastructure to Māori communities. In 1896 the Māori population hit a low point of 42,650 (Anderson et al., 2014, p.323). In 1903 it was estimated that fewer than half of all Māori infants reached four years of age (Bryder, 2015, p.96). Nevertheless, having survived the wars, land loss and the poverty that followed, and as the myth of a dying race persisted, a population recovery was taking place. Sometimes that recovery was due to policies and practices of the government, but more often it was despite them. Recovery was a struggle and left its

¹¹ The name ‘Wahine Toa’ has been used to protect the identity of this tupuna and her whānau. The record of her admittance to the asylum is at: Auckland National Archives, YCAA, A441,1048.

own scars. Wahine Toa, unable to communicate to an asylum doctor, sought relief in her reo and karakia. He aha te mate, Wahine Toa? What was wrong, Wahine Toa?

Autonomous Initiatives Begin

Maui Pōmare, Apirana Ngata, Hamiora Hei and Te Rangi Hīroa (Peter Buck) were members of a larger cohort, all educated at Te Aute College and influenced by their principal there, John Thornton, and by James Pope's 1884 *Health for the Māori*. They expressed the belief that the future welfare of Māori communities lay with health reform from within (Dow, 1999, p.90).

Central to that aim was Māori autonomy and the development of a modern Māori health-care system that combined the principles of oranga with western health practices. It included the establishment of regional Māori councils, which oversaw the needs and work being undertaken by community-based councils. In this way Māori communities were charged with improving sanitation and housing in their rohe, with Māori sanitary inspectors and trained Māori nurses supporting them. Indeed, Māori were at the forefront of Māori health and land reforms in the early twentieth century (Durie, 1998, pp.42-44). This is the period which Mason Durie dates as the starting point for Māori health improvements in the early twentieth century (Durie, 1998, p.44).

The first legislative steps toward that goal came in the form of the Māori Councils Act 1900 and the Māori Lands Administration Act of 1900, both drafted by Ngata and James Carroll, the first Māori Native Minister. Carroll described the Māori Council Bill 'as an effort on the part of the Māori race to organise themselves for a measure of self-government' (Dow, 1999, p.99). Indeed, Binney and O'Malley (Anderson et al., 2014, p.330) discuss how communities set by-laws in order to control such things as local resource management, agricultural endeavours, the sale of liquor, and to improve water supply and sanitation. Communities also raised funds to help implement suggestions made by visiting Māori sanitary inspectors and Maui Pōmare and Te Rangi Hīroa who toured the country advising community leaders. However, Binney and O'Malley point out that the efforts of Māori communities were undermined by Pākehā who did not respect or acknowledge the authority of Māori by-laws and, more importantly, the government's failure to sufficiently fund the work of Māori councils and to provide personnel who could support them (Anderson et al., 2014, pp.330-331).

Life-threatening Failures

A major problem during this period was the government's failure to administer and fund Māori health in an equitable, tribally responsive and consistent way. As the previous chapter shows, this was not a new problem, but at this time it clearly obstructed Māori attempts to promote autonomous tribal wellbeing, and quite simply, threatened the lives of Māori people who required health care. At one point the funding issue became so exasperating for Hīroa that in 1909 he stated that 'unless the Government were willing to spend a reasonable amount in attending to the health of the Māoris, they might as well let them die out' (Dow, 1999, p.101). The underfunding of Māori health was in part a direct outcome of the government's failure to commit

itself to a solid plan for Māori wellbeing. But the overarching factor was the persistence of an assimilation agenda, underscored by racism and an unwillingness to devolve power to Māori communities.

In 1900, funding for Māori health continued to be drawn from the 'Civil List' under the Constitution Act 1852 and administered by the Justice Department. A figure of £7000 was allocated for Māori purposes, and from that 'approximately £3,000 was earmarked for health expenditure on Māori' (Dow, 1999, p.95). How those funds materialised on the frontline, however, was complex and inefficient. The same year that the Māori Councils Act and Māori Lands Administration Act were passed, the Department of Public Health was established (Durie, 1998, p.118). Pōmare, who was appointed Māori Health Officer in 1901, pushed for the Department of Health to take charge of the civil list funds, but this did not occur until five years later. Meanwhile, the Justice Department paid the salary of Hīroa, who in 1905 became Pōmare's assistant.

Some rationalisation of the roles, responsibilities and funding of Māori health occurred in 1906, when the Department of Health was formally made responsible for Māori health. That responsibility included: 'complete control of Pōmare and [Hīroa] and the Māori sanitary inspectors, payments to [Native Medical Officers], medicines distributed by schoolteachers, the suppression of epidemics, and control of hostels used as nursing homes' (Dow, 1999, p.95). However, the Native Department and Health Department haggled over the allocation of Māori health costs and how much of the civil list funds should be distributed to their respective departments.

In 1909 responsibility for Māori health was transferred from the Health Department back to the Native Department, which had been reinstated in 1906. This again created tensions between both departments about their respective roles and funding responsibilities. The overlap between Health Department doctors, Native Department approved nurses, County Councils, the police, and Native Medical Officers all confused attempts at implementing Māori health policy (Dow, 1999, p.97). During the 1911 debates between the Health and Native Departments, it was suggested that a specialised department be created to deal with Māori and infectious diseases, though this would not happen for some years. By 1913, 85 percent of Māori were believed to be unvaccinated for smallpox, findings so poor that Hīroa invited Parliament to have vaccination made compulsory for Māori (Dow, 1999, pp.138-39).

In 1920, administrative control of the Māori councils was again transferred from the Native Department to the Health Department, and the call for a department dedicated to Māori and infectious disease was finally answered when the Division of Māori Hygiene was created under the Health Act of 1920 (Durie, 1998, p.44). Hīroa, who was appointed Medical Officer for Māori the year prior, was appointed Director of the new Division. Although many Māori councils had become inactive by that time, Hīroa attempted to revive them as Māori Health Councils which could communicate the needs of Māori on the ground to District Health Officers (Durie, 1998, p.44). In 1922, Hīroa claimed that a 'standard and objective' process for funding Māori health had finally been instituted. Theoretically the Health Department would cover costs for

councils and their sanitary works. The Native Minister was then ‘permitted’ to grant pound for pound subsidies from the Civil List.

In practice though, this rate was often not met (Dow, 1999, p.152). And, so, as loathed as the dog-tax was, some councils during the 1930s wished its return simply to sustain the viability of sanitary projects. In 1938 the Māori Council Chairman for Mangōnuī summarised the period, telling Health Minister Peter Fraser that the Māori councils had struggled for 30 years under severe funding shortages (Dow, 1999, p.153). The funding of Māori health between government departments would continue to be debated, but concurrently debates about responsibilities for Māori health also emerged between local and national bodies. In 1919 the Health Department issued a proposal that should there be an influenza recurrence, hospital boards would cover the cost of treating Māori patients. In response the Bay of Islands Hospital Board passed a resolution declaring categorically that ‘the health of Māori is a national and not a local responsibility’ (Dow, 1999, p.162).

Dow argues that a proposal in 1906 to replace Gilbert Mair with Maui Pōmare as Superintendent of Māori Councils showed government acceptance that European health reforms should be introduced by Māori... [who wore]... ‘Pākehā spectacles’ (Dow, 1999, p.122). Regardless, the fact is that the government did not support the autonomous institutions which it had legislated for under the Māori Councils Act of 1900 and Land Administration Act 1900 (discussed shortly), and Māori were often quickly replaced as key health decision makers and providers by Pākehā.

Autonomy Short Lived

From 1900, on the ground, the government’s failure to adequately fund Māori health impacted negatively on the autonomous institutions through which Māori could maintain oranga and reinforced the persistence of health inequities. How that occurred is summarised in brief assessments of the following: Māori nursing services, the vaccination of Māori, community sanitation programmes, hospital access, the treatment of tuberculosis, and infant care and mortality.

Oranga via The Native Health Nursing Scheme

Attempts to create an autonomous group of trained Māori nurses who would work in Māori communities began in 1901. Akenihi Hei, the first Māori woman to become a registered nurse, was of Te Whakatōhea and Te Whānau-a-Apanui descent, and was encouraged to enter nursing by her brother, Hamiora Hei, a member of Te Aute College Students’ Association. As exponents of the ideal of reform from within, they believed that Māori nurses would be better culturally placed to introduce western methods of health care into Māori modes of wellbeing in order to stem high Māori death rates caused by infectious diseases.

But achieving that vision was difficult. Akenihi Hei found the Native Health Nursing Scheme was severely undermined by low recruitment, a lack of funding and resistance within hospitals to the task of training Māori nurses. Within hospitals, Hei faced discrimination from those who believed Māori women had neither the temperament nor intelligence to successfully become nurses. The specifics of racist behaviour are not

clearly known in Hei's case, but it is known that well after her death, trainee Māori nurses continued to face discrimination. Some hospitals would not accept them, and other hospitals limited the number of trainees and/or trained them reluctantly.

Akenehi Hei also faced challenges within the Māori communities in which she worked. In 1909, she nursed in Te Kao and Pārengarenga in Northland during a typhoid epidemic. While her knowledge of te reo assisted her relationship with the people, Hei struggled with Māori patients who would not follow her instructions. The application of western medicines in Māori communities appears to have required a building of trust. She learnt as she went, and nurtured better relationships with the people of New Plymouth and Whanganui, where she worked in late 1909. When her own whānau members were struck down by typhoid in July 1910, Hei requested permission to take leave and care for them. Within months, she also succumbed to the disease and died in November in Gisborne Hospital. Tira Parone and Maud Mataira also died while nursing Māori during epidemics from typhoid or influenza (Bryder, 2015, p.89). The same year Akenehi Hei passed away, she had warned Pākehā nurses preparing to work in Māori communities to be mindful of Māori beliefs and customs:

Such customs (ancestral), having kept the Māori race in vigorous health for many generations, deserve consideration. They help Europeans to understand the workings of the native mind. A greater knowledge of the native mind will inspire a greater, and thereby a deeper sympathy for the Māori people, doing more for the uplifting of the Māori than all our Parliamentary laws and health regulations (McKegg, 1992, p.155).

The year after Hei's death the Māori nursing scheme was transferred to the control of the Department of Health and the vision held by Hei and Māori leaders for an autonomous Māori nursing system diminished. Between 1911 and 1914, recruitment remained slow and only twelve Māori health nurses were sent out into Māori areas to work alongside district nurses, who were predominantly Pākehā. Māori nursing struggled when regulations for scholarships were restricted to Māori girls educated at elite Christian schools, thus appeasing the moral requirements of the hospitals in which they trained (McKegg, 1992 p.150). Ultimately, even fewer Māori women were able to undertake nursing as a profession, and Pākehā district nurses continued to dominate the Native Medical Service. A combination of factors undermined the Native Health Nursing scheme. From government interference in the design and control of the schemes to the power of a Pākehā majority who held negative racial stereotypes about the cleanliness and moral integrity of Māori people within hospitals.

Health Inequity via Hospitals

That some Māori were reluctant to attend hospitals is therefore understandable. It had long been understood that some Māori afflicted with typhoid concealed their illness in order to avoid hospitals. In Taumarunui, infected Māori assaulted a nurse who had suggested hospitalisation (Dow, 1999, p.143). Such was the mistrust of western health care that identifying unreported typhoid sufferers became a key part of the work of Māori health nurses after 1910 (Dow, 1999, p.142). In partial response to this, camps or half-way houses were set up and run by nurses. For example, portable tuberculosis shelters were utilised on the East Coast as late as 1937 (Dow, 1999, p.193). Here Māori sufferers of typhoid especially, could receive health care without

having to travel to hospitals (Dow, 1999, p.191). Carroll proposed in the early 1900s to establish Māori cottage hospitals, staffed by Māori. The idea was popular among Māori and Wairarapa Māori who were willing to fund half the cost of such a hospital as well as provide the land. The Māori hospitals never eventuated, the exception being the erection of a cottage for a new Māori health nurse in Te Araroa in 1907 (Dow, 1999, p.109).

Oranga and Health Equity via Sanitary Inspectors

Māori sanitary inspectors also faced discriminatory employment practices while undertaking the difficult task of curbing the effects of infectious disease among Māori. From the outset, they were ‘dismayed’ at the treatment of their institution by the Health Department (Dow, 1999, p.125). In 1905 several Māori sanitary inspectors were in Northland and Ruatoki, and Dow writes that by 1908 there were eight inspectors. Seven were Māori and earned salaries described by Ngata as ‘niggardly’, ranging from £36 to £50. However the eighth, Elsdon Best, was paid £150. Ngata was reassured by Health Minister Fowlds that salaries would be increased (Dow, 1999, p.126), however, the Māori inspectors faced further pay disparity when their salaries were reduced within a year of Fowlds’ reassurance.

As mentioned earlier, the institution of sanitary inspectors was abolished in 1911, without consultation with Māori. The same week this occurred, an indignant Hīroa sought clarification whereupon Fowlds had to ‘admit’ to the dismissal of all Māori inspectors north of Auckland. They were to be replaced by European inspectors. The General Council of Māori Councils protested the replacement of Māori with European inspectors ‘who through not understanding Māori customs and sentiment frequently cause unnecessary friction’. The General Council pleaded that ‘the claims of suitable Maoris for appointment’ be considered, but to no avail. The same year Native Minister Carroll, himself nonplussed at the Health Department’s decision, commented on the quantity of work inspectors had achieved given the paltry sums that they had been accorded (Dow, 1999, p.126).

Oranga via Māori Councils and Māori Land Councils

In 1900 the Māori Councils appeared to offer Māori communities a degree of control over their own tribal welfare, the recovery and development of their wellbeing. However, as illustrated, their ability to effectively exercise autonomy was severely undermined by a lack of funding, and a lack of governmental support for Māori initiatives, especially those that challenged the state’s assimilationist agenda. Many of these initiatives were related to the achievement of oranga; attempts to improve community sanitation, and to control the use and protection of their ancestral lands were all about providing whānau with wāhi kāinga or homeplaces that could sustain them culturally into the future.

Many of these aims were also reflective of the Māori Land Administration Act 1900. That Act was designed by Carroll and Ngata to empower Māori to retain as much Māori land as possible in Māori hands while accommodating growing Pākehā demand for it. Māori Land Councils were established and charged with earmarking unalienable papakāinga blocks. Given the alienation of Māori land the previous

century, it is not surprising that Ngata and Carroll had to convince Māori to place their lands under the authority of the councils. However, the autonomy of these councils was also undermined by settler criticism of the Act and what they viewed as a land-holding system. Under the Act, the Māori Land Councils were to consist of a Māori majority and one Crown appointed member. Indeed, the Liberal government faced an increasingly hostile electorate as settlers grew impatient with the leasing policy that had been emphasised by Carroll and Seddon. Where possible Carroll encouraged Māori to lease rather than sell their land. It was a compromise that provided Māori with an income while giving settlers access to land. Unable to satiate settler desire, the Liberal government would begin loosening the legislation to free up more Māori land for sale (Anderson et al., 2014, p.332).

Carroll worked with Ngata and Stout to form a commission of inquiry to assess how much land remained under Māori ownership and, after calculating how much land Māori needed to survive, how much could be released for lease or sale (Anderson et al., 2014, pp.332–333). The result of the commission was essentially bypassed, however, with the passage of the Native Land Settlement Act 1907. Under this legislation lands not occupied by Māori could be vested in Māori Land Boards to be leased and sold. Between 1905 and 1909 the Crown acquired 360,552 acres of Māori land (Anderson et al., 2014, p.333).

The 1909 Native Land Act further loosened restrictions on the sale of land. A different situation existed for land blocks with more than ten owners. Here land sales occurred when approved by owners' meetings. However, a variety of methods could be used to bypass the need for majority approval. 'It was quite possible, for a block owned by 100 or more people to be sold by as few as five owners, whose decision was binding on all others' (Anderson et al., 2014, p.334). These methods were soon redundant anyway with an amendment to the Native Land Act in 1913. This swept away any remaining burden to gain approval from the majority consensus of land owners. This amendment came under the Reform Party, led by William Massey. For both the Crown and private buyers the process of purchasing Māori land had now been streamlined (Anderson et al., 2014, p.334).

The alienation of the whenua was persistent and made possible through increasingly aggressive legislation. Between 1892 and 1900, nearly 3 million acres of Māori land had been acquired by the Crown. Less than half a million acres were acquired through private transactions, mainly sale. Between 1900 and 1911, under the Land Board system, a further 765,000 acres was acquired by the Crown, a considerable part of it through compulsory vesting after 1905. Between 1910 and 1930, some 2.3 million acres was acquired through the Māori Land Boards (a little of half by the Crown), and the Crown purchased a further 1.2 million acres by transactions that did not require Land Board approval (Anderson et al., 2014, p.334).

In this way land legislation and land purchasing continued to undermine the oranga of Māori people. The whenua was being stripped away.

Oranga via Land Development Schemes

With around 80 percent of the Māori population living rurally in 1926, Ngata introduced land development schemes on the basis that ‘long-lasting gains in sectors like health and education could be secured only if they centred on agriculturally based ‘industrial development’” (Anderson et al., 2014, p.367). Ngata also preferred to work through and with tribal leadership and social organisations, a strategy fundamental to his basic philosophy that the future wellbeing of te ao Māori was tied to the relevance and durability of traditional chiefly leadership (Durie, 1998, p.141). Whina Cooper was one of the leaders who ensured her community accessed the benefits of the schemes. She described how her community in North Hokianga was struggling at the time,

... the people were very poor. Most of them were road-making, gum-digging, and bush-felling ... They had no money to go [dairy-farming] on the land. After the timber was worked out and gum-digging became unprofitable, the people became poorer than ever. They were living in shacks and did not have any land in which to plant a few kūmara or other vegetables... some of them went round to [Pākehā] farmers and did a lot of work. They even asked for a bit of mutton and things like that in order to feed their children (Williams, 2015, p.42).

The land development schemes provided communities with a buffer against the harshness of poverty. Entire communities were able to pool their whānau energies into (usually) small-scale family farms. The farms provided small incomes and fresh milk and butter to whānau who were still reliant on the whenua and moana around them for kai. Life did improve. But, as the next chapter will show, the schemes were not a long-term success for most.

Health Inequity via Vaccinating (or Not) Māori people

A severe lack of funding also impacted attempts to improve Māori access to vaccinations. Part of the problem was the lack of clarity between provincial and central government about who was responsible for Māori health. Compounding this were competing funding claims. During the 1914 Australasian Medical Congress. Buck stated,

We Māori people have had much legislation passed in the interests of our health and welfare, but too often the dispensers of that legislation seem to have been more concerned about the mote in their neighbour’s eye than the beam in their own (Dow, 1999, p.102).

One aspect of the Māori Councils was to work in with marae committees and record Māori health statistics (Dow, 1999, p.99). In addition to recording, councils would attempt to improve Māori health by reviving earlier vaccination efforts begun under the Public Health Act 1872. Pōmare, appointed Māori Health Officer in 1901, toured Māori communities with Ngata and Carroll, Pōmare and Hīroa, giving advice on water supply and sanitary improvements, as well as introducing vaccination programmes. Their recommendations would be implemented by sanitary inspectors, who were often local leaders (Anderson et al., 2014, p.331).

In 1902 Pōmare issued a te reo Māori pānui encouraging Māori to get vaccinated. He claimed that this resulted in more than two thousand Māori being vaccinated, with

this figure doubling the next year. Among these were 630 Māori from the Urewera District, an area thought to be resistant to western medicine. By 1905 the figure nearly reached ten thousand (Dow, 1999, pp.136–137). By 1905 several Māori sanitary inspectors were in Northland and Ruātoki. However, in 1906, Inspector Rāureti Mokouiaarangi reported that very few children in the Rotorua and Rotoiti areas had been vaccinated as the public vaccinator was reluctant to visit outlying areas. At the same time in Ohaeawai, poor vaccination results were attributed to the school principal's 'refusal to sanction the practice during school hours' (Dow, 1999, pp.137–138).

In 1911, the year that saw the disbanding of the sanitary inspectors only 1.6 percent of babies born were vaccinated when Pākehā who were against vaccination opted out (Day, 1999, pp.183-184). In 1912 it was estimated that 85 percent of the Māori population was not vaccinated against smallpox. When a smallpox epidemic hit in 1913–14 it was mostly Māori among the 2000 cases and 55 deaths (Rice, 2018, p.4). The smallpox was a mild strain (*variola minor*) rather than a severe strain (*variola major*) which would have caused more deaths (Day, 1999, p.184).

Health Inequity: Racism and Disease

Newspapers at the time insisted that Māori were to blame for the smallpox epidemic because of their poor living conditions, including lack of sanitation (Rice, 2018, p.4). For example, the *Northern Advocate* (7 July 1913, p.5; cited in Day (1999, p.186) published in Whangarei, commented that 'a very considerable number of Māori people live in a state of the most degrading dirtiness [...] many of these places are simply breeding grounds of sickness and disease'. Māori strong family ties, sociability, and tangi customs were also spotlighted as reasons for the continued spread of smallpox. Māori culture was attacked directly, with the rationale being stopping the spread of the disease when it was actually about justifying 'European intrusion into Māori life' (Day, 1999, p.195).

The disfigurement caused by smallpox fuelled attitudes that, in turn, influenced the control measure put in place when an epidemic struck. These measures, such as mobility restrictions, were often justified on medical grounds. The colonies were highly susceptible to this as immigrant fears were fuelled by their knowledge of European smallpox epidemics. Day 'argues that such a situation arose in the 1913 smallpox epidemic in New Zealand whereby European racial attitudes were responsible for the severity of measures placed on Māori to control the epidemic' (Day, 1999, p.10).

The 1913 smallpox epidemic led to increased demand for vaccination, leading to a shortage of the vaccine in rural towns as cities were receiving the bulk of the supply. Gisborne, for example, received 200 vaccine doses for 12,000 Māori and Europeans. Māori were greatly disadvantaged by the shortage in supply, and then by prohibitions (issued 14 and 15 July 1913 by Valintine) on them travelling in the Hawke's Bay, Wellington and Auckland provinces unless they had a certificate of vaccination. Even when they travelled on foot to get vaccinated, Māori found there was no vaccine available or that the town they had travelled to was closed to them (Day, 1999,

pp.187-188). Some doctors were also unwilling to visit settlements to vaccinate Māori (Day, 1999, p.189).

Vaccine was frequently given to Europeans in towns first and the remainder was distributed to Māori. Hospital boards and town councils orchestrated the distribution of vaccine, as the designated local authorities for the Health Department. They gave more lymph to local practitioners who vaccinated Europeans first rather than vaccinate those most at risk from smallpox—Māori... Apirana Ngata, member for Eastern Māori, told the House that out of the first 1000 tubes of vaccine sent to the Gisborne district, Dr Wi Repa received only seven with which to vaccinate Māori (Day, 1999, pp.188-189).

Failure of the vaccination lymph left Māori even more seriously unprotected. In one case, so severe was the failure that Hīroa got a leave of absence from parliament to oversee the revaccination of the people of Northland (Day, 1999, p.190). The failure of the lymph and the lack of other effective European treatments for smallpox undermined Māori confidence in western medicines. Māori, did, however, understand the nature of the epidemic as many were deeply affected by it—burning houses where whānau had died, and they were aware that children might be stillborn if a pregnant woman contracted smallpox (Day, 1999, p.196). While Māori who tried customary remedies were considered by Europeans to be ignorant, western medicines and European doctors, both of which could also be ineffective against smallpox escaped ridicule. It was easier to put the blame on Māori than admit the inadequacy of European cultural remedies (Day, 1999, p.196).

The restrictions placed on Māori mobility, combined with the hysteria generated by the press about disease-carrying Māori people, created serious economic consequences for Māori—demands for Māori produce and Māori labour declined, and many Māori were prevented from leaving their settlements to work or to buy provisions. Likewise, schooling was disrupted for Māori children as the Education Board gave teachers the authority to exclude children on health grounds, including those who were not vaccinated. Some schools (e.g., a mixed school at Paki Paki) were closed even though the disease was not present, merely because it was attended by Māori children (Day, 1999, p.189).

Florence Harsant, a mission worker for the Women's Christian Temperance Union in the north in 1913, recorded in her diary several instances of discrimination against Māori which occurred during the epidemic (Day, 1999, p.191). Māori were discriminated against regardless of whether or not they had the disease (e.g., refusal of stabling for their horses, refusal of travel). Europeans, on the other hand, experienced no discrimination even if they had smallpox. Calls for the segregation of Māori were particularly strong in Auckland, as Europeans worried about the viability of a major trade exhibition in the city in December 1913. Segregation became a major concern from August 1913 onwards, enforced by city and town councils and hospitals. When a case of smallpox was notified the Māori settlement was quarantined and the police or Health Department officials stopped people leaving. Harsant's diary reflected the level of discrimination Māori faced.

...the white people simply discouraged them from coming anywhere near them if it was possible... in some places they couldn't even post a letter or uplift their pensions from the post office. There was a lot

more fear than compassion on the part of the white people. They didn't ask whether Māori were being looked after or anything else. They were just left to fend for themselves (Day, 1999, pp.193-194).

It should be noted that some evidence exists that Health Department's doctors and nurses who were sent into the field to assist Māori provided the best care they could with limited staff and resources (Day, 1999, p.198). In general, though, local boards provided little assistance and hospitals, even though instructed by the Health Department to assist Māori, often refused on the basis that Māori did not pay hospital rates. People in quarantined settlements, according to Day, therefore suffered from a lack of food and (if the disease was present) exposure to the disease within their communities (Day, 1999, pp.192-193). No provision was made in the settlements for the isolation of those infected (as was usual practice since the 19th century), and the quarantining of settlements continued until well after the recovery of the last case of smallpox (Day, 1999, pp.192-194). That last case of smallpox was notified in April 1914, but it wasn't until July 1914 that travel restrictions on Māori were lifted (Day, 1999, p.197). Day (1999, p.194) concludes,

In this epidemic excessive and often unnecessary procedures were imposed on the grounds of race... Although close proximity of communities did assist the spread of disease, it is likely that the lack of vaccination amongst Māori during the epidemic and their low levels of resistance were more important factors pertaining to its spread.

The First World War and the Ongoing War with Diseases

When World War one ended in 1918, celebrations around the nation were subdued by an influenza pandemic sweeping the nation. For Māori, the process of mourning whānau lost to the war—15 percent or 336 dead and around 40 percent (around 900) wounded—blurred into the suffering and casualties caused by the disease that came to mark time (Anderson et al., 2014, pp.345–346) Judith Binney and Vincent O'Malley write:

Māori of that generation remember the so-called Black Flu with horror. In the Waimana Valley, it is the marker of time: events occurred either before or after the flu (not the war) (Anderson et al., 2014, p.345).

The Māori death rate of around 2500 people was 7–8 times greater than the Pākehā death rate, but it is likely to be an under-estimate given incomplete death registrations for Māori (Rice, 2018, p.4). Rice (in Ministry for Culture and Heritage, 2018, p.6) suggests a higher Māori death rate due to: lower immunity, being largely rural (isolated), and having lower standards of housing, nourishment and clothing. Pool (1991, p.117–119) also asserts that the higher Māori death rate was because 'Māori were a socio-economically depressed minority, isolated from and thus effectively excluded from the health-care system'.

The impact of the influenza pandemic on Māori communities was immense. The number of deaths was so high that tangihanga or customary mourning practices were difficult to maintain and, eventually, were banned by the government to prevent the spread of infection. The impact of the epidemic was at once a cultural and, according to Geoffrey Rice, 'a demographic disaster' (cited in Anderson et al., 2014, pp.345–346). Māori at the time expressed their anger and grief, questioning the lack of support

Māori communities received. One account criticises the government's failure to support Māori and instead leaving them to 'rely upon their own knowledge of herbs and remedies to cope with the dread scourge' (Ministry for Culture and Heritage, 2019, p.6).

In the Waikato, Te Puea, niece to King Māhuta, implemented health measures during the smallpox epidemic of 1913 and during the 1918 influenza pandemic (Anderson et al., 2014, p.340). In this case, however, the politics of wellbeing was very much still about remaining staunchly independent from the government—exercising rangatiratanga over oranga without any interference. This stance was a continuation from nineteenth century conflict with the government. In the heart of the Urewera, Rua Kenena was also firm that his community at Maungapōhatu should control its own oranga. For example, Rua 'objected to government policies that stifled Tūhoe's collective leadership' yet also 'laid down rules about hygiene, and particularly about separating the water supplies for washing, cooking and bathing (Anderson et al., 2014, pp.337-8).

Oranga—Inside or Outside of the System?

The Western Way or No Way? The Tohunga Suppression Act 1907

Ngata and other Māori working in the government system set up programmes and tribal bodies designed to utilise western health concepts and practices for the benefit of Māori wellbeing. There was some room for cultural negotiation between Māori and western approaches to achieving oranga but as Mason Durie states, the Tohunga Suppression Act of 1907 'was a clear statement from the Government that health care would be firmly based on Western concepts and methods' (Durie, 1994, p.45). The Act was supported by Māori parliamentarians. Some argue that support may have been in response to a test of their loyalty to the government, that their support was out of concern for the erosion of customary tohunga practices, or for a desire to move completely away from tohungaism. Another popular reason for their support was the desire to douse the impact of Rua Kenena.

Whatever the reason for their support the presence and influence of tohunga in Māori communities had never sat well with Pākehā. In the 1800s missionaries noted that some tohunga care was effective and some not. William Williams referred to 'native doctors' in 1847, indicating that he had some respect for the care provided by tohunga. Reverend Richard Davis referred to a tohunga as a 'Waimate doctor' in 1859, but on another occasion expressed concerns (Dow, 2001, p.45). Missionary William Colenso regarded his medical work with Māori as about more than simply treating ailments, but also a means of lowering Māori regard of tohunga in their communities (Dow, 1999, p.21). European medical men tried to discredit tohunga from the 1840s onwards (Dow, 2001, p.46). Rolleston (1989, p.20) writes that 'at the turn of the century the Māori population was devastated by epidemics and the tohunga were seen by the western medical profession as a hindrance to the health of Māori people'. This 'lower class' of tohunga (identified by Best) were seen to be increasing in numbers. The tohunga of old had declined along with the decline of

whare wānanga and the encroachment of new technologies as well as diseases. Buck wrote that post-1840, Māori

...combined herbal remedies with a certain amount of native ritual and entered the same category as European quacks to such an extent that a Tohunga Suppression Act was passed by Parliament to prevent them from imposing on the credulity and superstitions of the people (Hīroa T., 1949, pp.407. Cited also in Dow (2001, p.63).

At the time of the Act, both Māori (e.g., Buck, Pōmare) and non-Māori (e.g., European doctors) were critical of so-called ‘pseudo-priests’ (Voyce, 1989, p.101). Voyce (1989, p.102) argues that ‘pseudo-tohunga’ emerged in response to poor housing and diet; a lack of government provision of health care to Māori; European doctors living in mostly urban centres reluctant to treat Māori in rural areas; some hospitals unwilling to admit Māori patients; Māori not wanting to see European doctors as they could not pay, and hostile/racist doctors and hospitals.

Māori themselves took a pragmatic approach and continued to consult with tohunga both before and after the passage of the Act (Dow, 1999, pp.127–128). Carroll, amongst others, pointed out that Māori often relied on tohunga since doctors could be 70 or more miles away (Dow, 1999, p.121). It was even worse than Carroll suspected. Half of the 30–50 subsidised medical doctors in the first two decades of the century were stationed in the South Island or near Wellington, so nurses in remote areas were often left to their own devices and were reliant on local communities for support and resources (Bryder, 2015, p.89). By comparison, tohunga would always be a viable option, especially if western health care was inaccessible. But whether the issue was about accessibility is questionable. Tohunga, as outlined in chapter one, were not just healers of the body.

The passage of this Act continues to attract much attention and debate. It represents a clear attack on one of the pinnacles of oranga – whakapapa, and the mātauranga and tikanga that holds as an important foundation of Māori identity and culture. It also attracts much attention because there are questions about who pushed for the Act to be passed and why. In 1904 there was a push back by Pōmare against tohunga in his annual report where he called for legislation against tohunga after 17 children died in just one pa after being administered by a tohunga. This report became a key driver of the 1907 legislation (Stephens, 2001, p.442). Pōmare’s criticism of tohunga included their disruption of settlements and kāinga, as people were parting with resources and getting into debt in order to follow a ‘prophet’. However, there was already provision in Section 240 of the Criminal Code Act 1893 for prosecuting those practising fraudulent and harmful healing practices, and four tohunga were convicted under this Act in 1900–01 (Stephens, 2001, p.456). For example, when people in Wairoa complained about a tohunga in their area and sought the protection of the law, the tohunga was eventually arrested and charged in 1901 under the Criminal Code Act 1894. According to Stephens, the Tohunga Suppression Act targeted other concerns; namely, it was designed ‘to neutralise the apparent threat offered to Māori employment by spiritual leaders such as Rua Kenana’ (Stephens, 2001, p.457).

James Carroll oversaw the drafting of the Act, with this recorded by Ward (1993, p.1) as reflecting his ‘impatience with what he considered regressive Māori attitudes’. He

was frustrated that his ambitions for Māori improvement/advancement were being derailed by what he considered to be Kenana's so-called isolationist agenda. Voyce (1989, p.108) notes that 'what really concerned the authorities was Rua's prediction of a Māori millennium that would see the return of Māori land at a time when European farmers in the Hawke's Bay and Bay of Plenty area were demanding more and more land'. In Webster's view, Rua also represented defiance of authority, with the government and possibly Carroll reacting as much to this threat to Māori 'development' and settler aspirations for land as they were to charlatans claiming to be healers. This explanation is borne out by the mere six tohunga, of the seven charged, who were convicted under the Act (Voyce, 1989). Stephens (2001, p.453) notes that fear and uncertainty was generated in Māori and non-Māori communities by proponents of millenarianism such as Rua Kenana who were linked with calls for Māori autonomy. Pākehā expressed their concerns about the potential havoc that could be caused to 'nascent industries' as after 1906 Māori were leaving their employment to follow Kenana (Stephens, 2001, p.457).

While the Act was talked about as being in the interests of Māori health, very little was done in the time of the Liberal government (1891–1912) to improve Māori health even though the government set up a Health Department and instigated the registration of nurses and midwives, the establishment of maternity hospitals and the passing of dental health legislation (Voyce, 1989, p.108–9). Voyce cites Sorrenson (1956) that the health of Māori during this time depended on the retention of land, and any concerns about Māori health were largely driven by poor Māori health being a threat to settler health.

Stephens (2001, p.449) speculates that the Tohunga Suppression Act 'was something of a litmus test of loyalty for some of the Māori members of the House'. Carroll, Ngata and Wi Pere all seemed at pains to explain to their parliamentary colleagues that they were not directly supporting tohungaism. Even so, Pere supported the Māori Councils and some tohunga, but explicitly distanced himself from Rua Kenana (Stephens, 2001, pp.448-9). Both Ngata and Carroll also used their support for the Act to protest Māori conditions and to request more Māori health resourcing from the House (none were forthcoming (Stephens, 2001, p.456), and expressed their belief that legislation would not control tohunga (Stephens, 2001, pp.449-50).

Stephens (2001, pp.450-1) queries why Rua Kenana was not prosecuted under the Tohunga Suppression Act when it seemed to be tailor written for his prosecution. She writes that if parliamentarians saw him as the recipient of the powers in the act, their views had changed the following year, 1908, when he became known as amenable to the sale of Tūhoe land. By 1910, notwithstanding his strong words against Rua in the debates on the Act, Ngata brought Rua on to the General Committee that had been established as a negotiating body for Tūhoe, and Rua sold some 40,000 acres in the Maungapōhatu district to finance his community at Maungapōhatu (Stephens, 2001, p.452).

Much of the debate about the Tohunga Suppression Act 1907, seeks to prove one way or another that the state was responsive to Māori concerns about the authenticity of tohungaism or conversely exercised its powers to crush one of the most sacred agents

of Māori culture. Regardless, the Act created a situation for Māori whereby the customary practice of consulting with tohunga was made illegal. Whether they continued to consult with tohunga or not, it became a hidden and shameful practice. Healing could only be accessed legally through the western health system.

Ratana and Health

Following the 1918 influenza pandemic, Tahupōtiki, Wiremu Ratana emerged as a healer and the founder of the Ratana movement, a Māori faith-based and political movement. Ratana joined Ngata in filling a void in Māori leadership at this time and he sought to unite all Māori ‘under the Bible, and the Treaty of Waitangi as the guarantee of Māori rights’. Ratana, like Ngata, was also strongly influenced by James Pope’s *Te Ora mō te Māori*, but his Treaty politics shaped his view the tribal councils were an infringement on, rather than an extension to, Māori sovereignty (Dow, 1999, p.100). This did not mean that Ratana was unwilling to fight for oranga within the system, however, and in 1928 the Ratana movement entered New Zealand politics and by 1943 had captured all four Māori seats (O’Malley, Sterling & Penetito, 2010, p.237). Ratana Pa became a beacon to Māori (and non-Māori) seeking healing powers. Regardless of where Māori went, however, they could not escape the poverty that made them vulnerable to disease.

Oranga and Economics

It is apparent that Māori members of parliament during this period pushed for policies that would incorporate western health practices and medicines into a modern model of tribal wellbeing. Attempts were made to nourish oranga by reinforcing tribal leadership, collective values and practices, and by slowing if not halting the sale of Māori land. This strategy was introduced alongside strategies to improve Māori health (in its western sense). Some in-roads were made but, again, the government’s failure to fully support and fund programmes initiated and legislated for, significantly undermined oranga and failed to stem the health inequities. To the state, Ngata’s land development schemes were viewed as economic rather than health-based initiatives. The government’s priority at the time was to assimilate Māori into a national and mono-cultural framework of health care, not fund a modernised Māori system of wellbeing/care.

Bryder (2015, p.86) writes that Māori mortality and illness in the early 1900s was a reflection of Māori poverty, such that infectious diseases killed Māori in far greater numbers than Pākehā. For example, no Pākehā lost their lives in a 1913 smallpox epidemic, but 55 Māori died. In 1916 it is estimated that there were 258 cases of typhoid in one small Māori village. In 1918 ten times more Māori died from influenza than Pākehā. In the 1930s, the first accurate estimate of tuberculosis reported that the rate of the disease was ten times higher in Māori than non-Māori (Bryder, 2015, p.85).

As the health of Māori was kicked between local and national government bodies, and the racism that fuelled fear and paranoia among Pākehā led to the neglect of Māori requiring medical assistance, Māori people died. Binney and O’Malley write:

By 1921, the Māori population of 53,000 in 1916 had barely re-established itself (Anderson et al., 2014, p.345)... It was mainly the young adults who died, out of a population which had already lost too many of its young men. The generation who were to lead Māori in the critical years of the later 1920s and 1930s had been significantly weakened (Anderson et al., 2014, pp.345–346).

Equality, Universal Welfare and Racism

‘The diseases affecting Māori at this time were largely the diseases of poverty and were to a significant extent related ‘to the continuing frustration of the people’s ability to earn income by leasing and developing their own land’ (Anderson et al. p.332). However, Māori poverty also was a situation perpetuated by the government in terms of social welfare provisions.

Following the introduction of limited pensions in the 1890s and relief payments in the 1920s, New Zealand took a major step towards becoming a welfare state in 1938 when the First Labour Government introduced the Social Security Act. In theory, the Act provided all New Zealand citizens with access to a range of social welfare benefits. As Margaret McClure notes, however, ‘the Act failed to bring immediate equal benefit payments to Māori’ (McClure, 2013, Kindle Edition, p.2368 of 7248). Māori received lower rates of the Widow’s benefit, the Old Age Pension and throughout the 1940s Māori were also placed under intense scrutiny if they received Family benefit payments.

Much of this pressure came from Pākehā and state officials who questioned Māori entitlement on the basis that Māori did not need the same level of financial support as Pākehā families living in more urban areas. Most Māori remained in their rural communities at the time and it was considered that Māori could either live of the land or that their life in the Pa provided enough collective support for them to get by.

The payment to Māori of reduced benefits was made under Section 72(2) of the Act, which provided officials with discretionary powers to lower payments if ‘the maximum was seen to be not “necessary for the maintenance of the beneficiary”’ (McClure, 2013, Kindle Edition, p.2376 of 7248). Similar discretionary powers had actually been in effect from the 1920s when Māori consistently received lower relief payments. From the 1930s well into the 1940s this remained in place. Examples of the practice included lowering the payment of Old Age Pensions to Māori who distributed it within their homes to mokopuna, the saving of pensions, or the purchase of goods deemed unnecessary. As Margaret McClure writes, ‘whilst old-age pensions lessened Māori poverty the tendency to pay lower pension rates to Māori reinforced the difference between Māori and Pākehā communities’ (McClure, 2013, Kindle Edition, p.578 of 7248). The surveillance of Māori whānau and homes was also incredibly intrusive, with claims from officials and other agents co-opted into watching Māori communities, referring to homes in which children were left unattended in ramshackle homes while parents drank away their benefits (McClure, 2013, Kindle Edition, p.2484 of 7248).

Housing

While Bryder identifies poverty as a major contributing factor to poor Māori health, she also points out that poor housing was probably the main driver of Māori tuberculosis, something the government was well aware of (Bryder, 1991, p.125). The government passed the Native Housing Act 1935, but it was a low priority for government(s) of the time and only 478 houses were built by 1940, even though 45,000 Māori were thought to be inadequately housed. Māori were living in houses that were overcrowded (57% of Māori), had unsafe water supplies (45%) and/or were generally unfit for human habitation (36%) (Bryder, 1991, p.125). Poor housing placed Māori at a greater risk of morbidity and mortality at the turn of the century (Lange, 1999, pp. 20-21), with promises of racial equality made by the newly elected Labour government in 1935 not coming to fruition in terms of State housing because of racism, urban housing development, and a philosophy of cost-recovery, all of which put these new houses out of the reach of most Māori.

By 1949, the building of 32,000 state houses also failed to alleviate the housing crisis faced by Māori. Allocation committees responsible for granting access to state housing were racist and even if Māori got through the allocation committee the houses were in urban centres and the cost-recovery principle applied by the government meant that rents were one-third of the average wage. Both factors put state house beyond the reach of many Māori. As discussed in the following chapter, it took the intervention of the Department of Māori Affairs in the 1950s to increase the number of houses being built for Māori, with more than 5000 homes built by 1955 (Bryder, 2001, pp.83–84).

When did Māori Lives Count? Tuberculosis

While the New Zealand Department of Health was set up largely in response to a plague scare, its attention was soon focused on tuberculosis. It was known at the time that tuberculosis was responsible for around one in every 10 settler deaths, data on the impact on Māori – who suffered ten times the rate of tuberculosis as settlers - did not become available until the 1930s (Bryder, 1991, p.109). Many of the initiatives put in place in the early 1900s (e.g., sanatorium for the treatment of tuberculosis) were for the benefit of the settler population (Bryder, 1991, pp.109-110).

The calculation of the cost of tuberculosis deaths in 1903 was estimated to be 304,000 pounds due to 800 (presumably settler deaths), and the definition of tuberculosis as a national menace detrimental to ‘national efficiency’ (Bryder, 1991, p.111) also only applied to settlers. So, not only were Māori not counted or likely cared for in the latest facilities put in place by the Department of Health (e.g., sanatorium – the first one opened in 1903) (Bryder, 1991, p.112), their deaths were not included in the calculation of the lost efficiency for the nation.

In 1928 the lack of evidence about Māori and tuberculosis was noted (Bryder, 1991, p.123), and the first systematic study was undertaken by Turbott (Health Officer, Gisborne) on the East Cape in 1933. The results showed a rate of tuberculosis of 56.8 per 1000, with a death rate of 4.96 per 1000. What followed were various anecdotal reports of high tuberculosis rates in Māori communities, and the rejection of a large

number of Māori tuberculosis sufferers who volunteered to fight in the Second World War (Bryder, 1991, p. 123).

Turbott attributed the high Māori tuberculosis rate to: poverty and malnutrition, poor housing, social customs, and reluctance to seek treatment (Bryder, 1991, p.124). Remedies proposed within the ideology of ‘self-help’ included: education (to break down customs, overcrowding, etc) and strengthening the district nursing scheme (Bryder, 1991, p.124). Turbott stated: ‘Unfortunately some public hospital authorities are unsympathetic to Maoris, do not provide as complete a service as for Europeans, and some staff either show, or the Māori instinctively detects, racial antipathy’ (Bryder, 1991, p.125). Turbott also found there were not enough beds to cater for Māori tuberculosis sufferers (e.g., 30 beds for 115 patients), and that Māori sometimes had to travel long distances, away from their families, if they wanted hospital / institutional care (Bryder, 1991, p.125). Bryder argues that the campaign against tuberculosis, with its emphasis on institutions, discriminated against Māori ‘who were least likely to seek admission to an institution’ (Bryder, 1991, p.115). Single person huts (hutments) were provided to Māori TB patients from 1937, as a realistic alternative for Māori who did not want to go into hospital treatment – as this was often at a hospital some distance from their home (Dunsford, 2008, p.44).

There existed a view that Māori were resigned to having tuberculosis and thus were unwilling or disinterested in their own wellbeing. ‘Dr G.M. Smith of Hokianga claimed that sanatoria and hospitals for the Māori were a waste of money in any case and that education was far more important’ (Bryder, 1991, p.125). The presumption among health officials that Māori were resigned to TB, however, is countered by the fact that Māori sought information about the BCG vaccination in 1938 (Bryder, 1991, p.125). Unsurprisingly, perhaps, those inquiring were told that the vaccination was opposed by medical people and that education was the best response for Māori (p.126). Then, Māori in Taranaki purchased a mobile x-ray machine in 1941 – the first in the country so that they could survey the Māori population through chest x-rays (Bryder, 1991, p.126).

An increase in TB in 1942 was seen as a consequence of war, but media reports were about the rediscovery of the disease after it had been out of the public eye for many years (Dunsford, 2008, p.46). However, TB had remained a present disease for Māori. In 1942 statistics showed New Zealand’s European-only TB death rate of 3.9 per 10,000 was still one of the lowest in the world. However, the Māori figure of 42.2 per 10,000 was one of the highest (Dunsford, 2008, p.25-6). In 1943, TB still represented a problem for the general Pākehā population but it was a problem on a vast scale for Māori. It was clear that Māori were the key to any New Zealand TB solution (Dunsford, 2008, p.56).

Hospital Boards grappled with high Māori TB rates, with this being a financial issue for those Boards with serving high Māori populations. Because Hospital Boards were raising funds partially from land tax or rates, this portion of their funding came largely from Pākehā that was rateable). Māori were also largely still seen by Hospital Boards as not taking responsibility for their own health. This view was strongest in the Far North, with Hospital Boards there recommending that Social Security benefits for

Māori be dependent upon their self-improvement in housing, hygiene and nutrition (Dunsford, 2008, p.56). Fuelled by their belief that Māori TB was as much a social and economic problem as a medical one the hospital boards in the Far North were reluctant to fund a sanatorium for a disease that largely afflicted the Māori population in their region, even though Māori paid Social Security tax (which made Māori TB, in the Boards' view, a central government problem) (Dunsford, 2008, p.57).

In 1943 the Department of Health formed a Division of Tuberculosis, following the recommendation made by the 1928 Royal Commission of Inquiry (Dunsford, 2008, p.47). The Division began to co-ordinate TB services, rather than leaving services in the hands of individual hospital boards (Dunsford, 2008, p.18, exact date, p.30). It was also argued that boards with more Māori should not be left to provide care unaided (Dunsford, 2008, p.57). While x-ray screening for TB was available at this time, effective drug treatment was not (Dunsford, 2008, p.48). Tuberculosis conferences in Palmerston North and Auckland in 1943 (Dunsford, 2008, p.52) both recommended more attention being paid to tuberculosis control among Māori, as well as surveys of the housing conditions of TB sufferers (Dunsford, 2008, p.53).

There was growing impetus to see the TB infection rate among Māori as a shameful indictment of the country's health status, and also as a potential threat to the health of Pākehā. With international comparisons becoming more common, the Māori TB rate also challenged the Labour Government's idealism, brought on by its allegiance with Ratana Māori, about Māori benefiting equally through its social programme. Even so, the media strengthened its stance during this time that TB reflected poor living standards, overcrowding and bad nutrition. These featured large in the public debate about TB (Dunsford, 2008, pp.58-9).

In the years from 1943-1953 there was a growing commitment to a system of TB prevention, diagnosis and treatment (Dunsford, 2008, p.61), underpinned by the development of a new National Tuberculosis Register (p.62). In May 1944, a staggering 6772 (new and existing) cases of tuberculosis had been registered, with 377 new cases added in the Division's first year (Dunsford, 2008, p.62). The following year added to the depth of information and gave a clearer picture of TB among Māori in particular. The notified incidence rates for European New Zealanders were identical in the North and South Islands at 3.47 per 1000 of population; however, Māori rates were about seven times higher than those of Europeans at 23.24 per 1000 of population in the North Island and 25.48 per 1000 of population in the South Island (Dunsford, 2008, p.62). In the Division's second year of operation the American formula they applied to the registered Māori cases suggested that there were nearly three unregistered cases of tuberculosis ($n=1629$) for every registered case ($n=2131$). This pointed to many more Māori cases of tuberculosis needing to be identified (Dunsford, 2008, p.62).

The government's failure to investigate the extent to which tuberculosis was affecting Māori communities in a timely way is clear, as is its failure to ensure that Māori received adequate treatment. Underpinning these failures, like many others in this report, was the persistence of racist attitudes and an indifference to Māori welfare, spurred by what appears to have been the economic costs of treating Māori.

Infant Mortality and Plunket

Pool argues that Māori lived in isolated areas and thus effectively excluded from the health-care system. There is much evidence to support the former. Isolation does not, however, account for the exclusion from the latter, at least in the area of infant welfare. The reasons were far more complex, from administrative territorial disputes to local racial prejudices and culturally insensitive services or nurses. Plunket did not set out to exclude Māori positively. Indeed, Harold Turbott complained in 1962 that Plunket was ‘soliciting’ Māori mothers. However, in the pre-1960 period, Plunket Society members did not defend that territory with the same determination that they defended the right of European communities to have their own Plunket nurses. This is not surprising, given that the women who ran Plunket raised funds for their services and saw themselves as united in a bond of sisterhood and common interests. But they also claimed considerable public money.

In a country proud of its social welfare services and its infant welfare services in particular, and also proud of its race relations, the reality was that during the first half of the twentieth century a dual system evolved in infant care which left Māori disadvantaged. The primary health care provided to the European population through the world-famous Plunket Society clinics and its nurses did not accommodate Māori (Bryder, 2001, p.86).

The exclusion of Māori was rationalised by the Plunket Society as being about the insufficiency of the funding it received from government. However, the targeting of this funding to only Pākehā reflected concerns being expressed at the time about the future of the Anglo-Saxon race. The Society chose this concern rather than the delivery of infant welfare to those who most needed it, and conveniently removed itself from a territorial dispute it was having with the Department of Public Health. The latter had established its own district nursing scheme in 1909 along with a Native Health Nursing Scheme two years later (Bryder, 2001, pp.69–70). Infant health was a priority for both, and by 1918 there were 18 district nurses (Bryder, 2001, p.69). This number had risen by 50 in 1984 but still fell short of the 138 Plunket nurses who were working that same year. All these nurses, district and Plunket, were Pākehā. In 1934 the Society was lauded for its work in reducing infant mortality by Governor-General Lord Bledisloe. Māori infant mortality rates were conveniently excluded from the statistics in the New Zealand Official Yearbook that year (Bryder, 2001, p.67).

The introduction of a ‘combined scheme’ in 1940 set the tone for the Health Department’s goal that Plunket would confine its services to ‘cities and populous areas’. In the combined scheme the same nurse would undertake both district and Plunket duties, effectively leaving rural districts under the Department’s watch. This met with some resistance from mothers in rural areas, who either wanted a Plunket nurse and/or did not want their infants seen by a nurse who was also seeing Māori women and their infants.

A 1949 letter from Pākehā mothers in Tolaga Bay to Plunket’s Nursing Advisor spelt out their concerns about the combined arrangement, including a familiar discourse about Māori suffering diseases and being a potential source of infection for their infants and families. A similar response expressing theories about the probable contamination of white families by Māori families was received from Kaitaia. Further

inquiry found that the two district nurses in the area were not welcomed into Pākehā homes as mothers did want them to visit after they had been to Māori homes. In their 1950 letter to Health Minister Jack Watts requesting a Plunket nurse of their own to do European work, the Pākehā women of Kaitaia described the district nurse as a ‘Māori nurse’. They later changed their minds and Māori mothers were invited to bring their babies to the Plunket clinic in Kaitaia, possibly because a Māori baby had won a fundraising competition to raise money for a Plunket nurse (Bryder, 2001, pp.71–73).

Plunket’s 1958 film ‘Born in New Zealand’ claimed that Plunket did not exclude anyone. This was based on Plunket policy that their nurse would not go to Māori pa, but Māori mothers and infants were welcome to attend Plunket clinics. The film was followed in 1960 by reassurance in the *New Zealand Herald* from Plunket’s Auckland branch president, Mrs Sheila Horton, that mothers of any race were welcome at Plunket rooms. This was soon shown to be inaccurate, as Plunket nurses in several locations refused to see Māori mothers. Findings from a survey of Plunket nurses carried out by Plunket’s Director of Nursing, Miss Sydney Lusk, however, also found that Māori mothers were resistant to ‘the idea of continuous supervision of their babies’ (Bryder, 2001, pp.73–74).

Unsurprisingly Māori engagement with Plunket services prior to 1960 was limited. Plunket nurses did not visit Māori mothers in their homes as they did Pākehā mothers, so relationship bonds were weaker even before the mother experienced racist behaviour from nurses at Plunket rooms. Plunket was born and grew up as a monocultural organisation run by and for Pākehā women. They had minimal contact with Māori and preferred it that way, although this did not prevent them from putting remits to their conferences about the poor state of Māori infant health (Bryder, 2001, p.75).

Mental Health Continued

He Aha te Mate—What is Wrong?

Wahine Toa might have felt that everything was wrong or not tika when she was admitted to Auckland asylum in 1905. Everything that sustained oranga was being chipped away. An issue to do with her whenua had upset her – something many Māori would have felt at the time. But how it looked and felt on an everyday basis to Māori living in poverty, perhaps as survivors of warfare or disease, is hard to imagine. To the authorities—politicians, nurses, doctors, police, civil servants—Wahine Toa was part of a ‘Māori problem’, whereby she was not educated enough, concerned enough, or motivated enough to take responsibility for her own wellbeing. She was a public nuisance, dangerous, and had ‘acute mania’.

We need to be careful about how we frame and understand this tūpuna, Wahine Toa. The way in which the western framework of health assigns illnesses to specific health sectors may actually distort the living realities of Māori lives, values, experiences and worldviews of wellbeing; in the case of Māori: oranga. No one should be quick to utilise specific frames (like mental health) in the name of universal care or equality. In the past, that has been the default position. The state and academic researchers, often

in tandem, have sought solutions that explained away the state's role in the bigger picture of Māori poverty and disempowerment, cultural dislocation and marginalisation as 'the Māori problem' or a 'mental health' issue, as was the case in 1908, when Maui Pōmare stated, 'No doubt as the Māori progresses and becomes more modernised in his every-day pursuits the wear and stress of civilisation will be made more manifest by nervous breakdowns' (Dow, 2006, p.176).

It is necessary to go back to the 1860s to unravel the history of Māori and the 'mental health system'. This is when Māori came to the attention of psychiatric authorities at Auckland asylum (known as the Whau). More males than females became subject to asylum life, and it has been theorised that contact with European employers or the police could have resulted in committal to an asylum (Coleborne & MacKinnon, 2006, in Ball, 2010, p.39).

Durie expands on this, writing that between 1854 and 1867, four asylums were built in New Zealand and 'Institutional care quickly became a characteristic of New Zealand's mental health system'. The three 'competing objectives of asylums were 'the treatment of so-called medical conditions such as insanity, the care of the socially rejected, and custody of those who posed threats to community safety' (Durie, 2004, p.2–3). Durie writes that,

...moral considerations, humanitarian ideals and scientific principles gradually led to a re-conceptualisation of insanity as a type of illness. At the same time admission criteria to asylums erred on the side of social responsibility, catering for the poor and indigent as much as the sick or disturbed (Durie, 2004, p.2).

The number of Māori who entered the system was low in the nineteenth century. Dow (2006, p.33) provides evidence for mental illness among Māori with some early anecdotes. The first is from 1857 when Dr Edward Hulme the first medical superintendent of the Dunedin Hospital and Asylum complained that he could not admit a mentally-ill Māori woman since the spare room was occupied by the Chief Constable who had it as his residence. In 1881 only five 'lunatic Māori' males (all over the age of fifteen) were recorded at Auckland's Whau Asylum (Dow, 2006 p.176). In 1887, three Māori were committed for lunacy in Napier, one of whom was a woman 'whose brain was affected by the [Tarawera] eruption' (Dow, 2006 p.176).

Te Kani Kingi (2005, p.4) speculates that the mental health problems Māori may have been facing were simply less visible in the face of overwhelming illness and deaths from infectious diseases. Official statistics may also have missed counting Māori who were less likely to access mental health care, preferring instead to remain at home and be cared for by whānau. Kingi's third possible explanation is that mental illness among Māori was rare. (Kingi, 2005, p.5). The idea that Māori may have preferred to remain at home with whānau is supported by the following exchange between Richard Seddon and the people of Poroti in 1894. There he was met by a call for the release of a chief being held in a lunatic asylum. The community claimed that his condition had not improved while institutionalised and they wanted him returned so they could care for him. However, Seddon responded with a story concerning a patient who had killed upon being released. He instead promised to investigate and

help pay for the family to visit the chief if he was not considered safe for release. (Dow, 2006, p.176).

By the 1930s, Māori who appeared to be mentally unwell became objects of deeper scientific investigation. Beaglehole (1939, p.149) detailed the higher incidence of ‘manic-depressive insanity’ in Māori women. His hypothesis, overall, was that Māori were still being ‘remoulded’ to European ways but that enough adaptation had occurred to make for successful diagnosis of people with schizophrenia or manic-depressive (Beaglehole, pp.154–5).

Beaglehole (1939, p.144–145) compared Māori and Pākehā incidence of psychosis, 1925–35. The rate for Māori males was below the rate for European males, only approaching the same incidence in 1933. The rate for Māori females was below the rate for European females, only approaching similar incidence in 1930 and 1934. This data classifies Māori as those with half or more Māori blood (Beaglehole, 1939, pp.145–6). In looking for explanations for disparities in incidence of psychosis Beaglehole looked at a number of statistics:

- Māori were a younger population (mean age of 23.43 years in 1926 compared to 29.23 years for Europeans) (Beaglehole, 1939, p.146)
- The median income for Māori males over 15 years was 120 £/annum vs. £205 for European males (Beaglehole, 1939, p.147)
- Māori were largely still living in rural districts (Beaglehole, 1939, p.148)

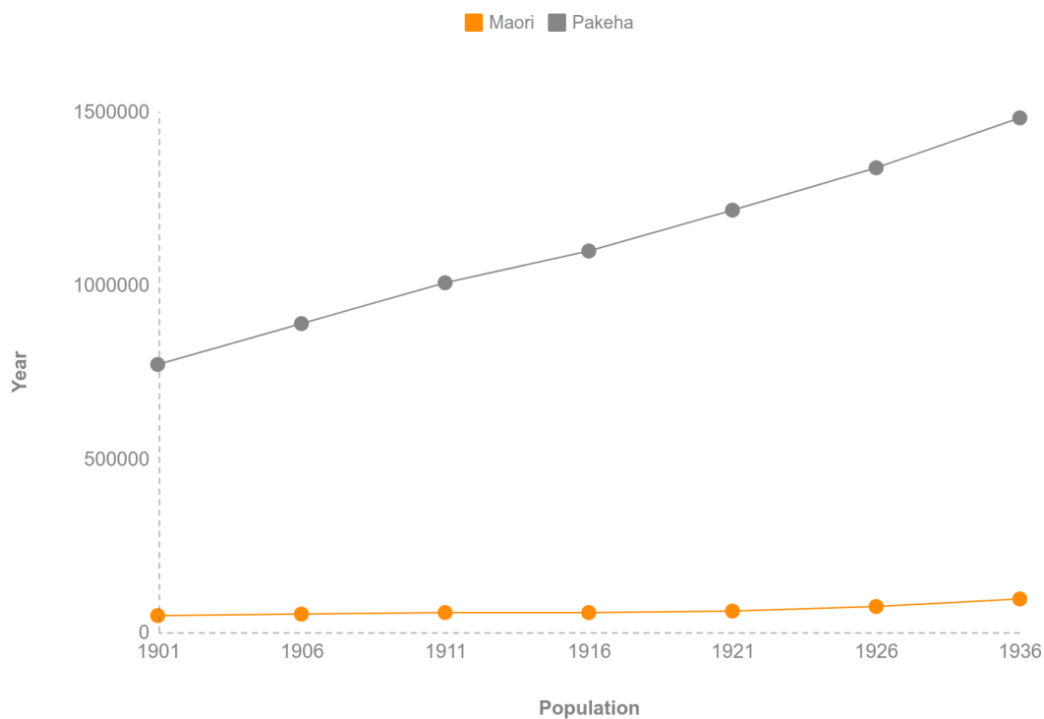
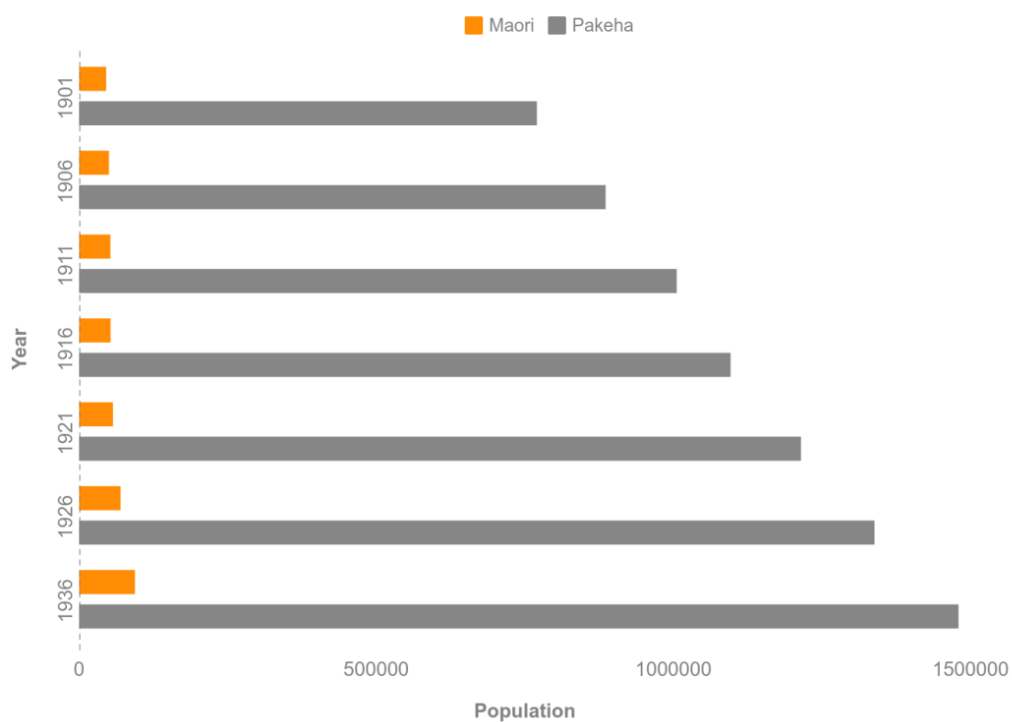
By 1941, the New Zealand mental health system housed just over 8,000 patients, 164 (2%) being Māori. In 1948 the Mental Health Department was absorbed into the Health Department, re-emerging as the Division of Mental Hygiene. By this point the number of Māori mental health patients had increased somewhat to 237 (of 8,708). The relatively low proportion of Māori mental health patients meant that little interest was given to Māori mental health during the 1940s and 1950s. By the mid-1950s Dr Geoffrey Blake-Palmer (who succeeded Ronald Lewis as Director of the Division of Mental Hygiene in 1960) acknowledged the existing system did not function well for Māori. As the following chapters will show, the system would not function well for Māori across the health board for many years to come.

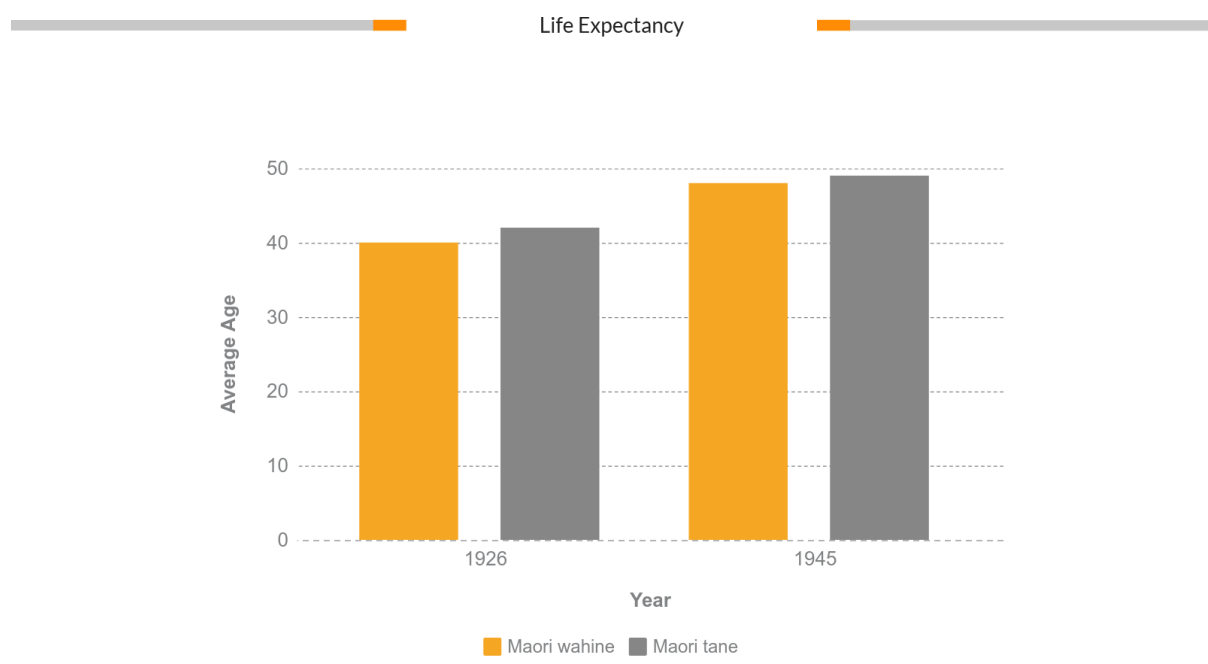
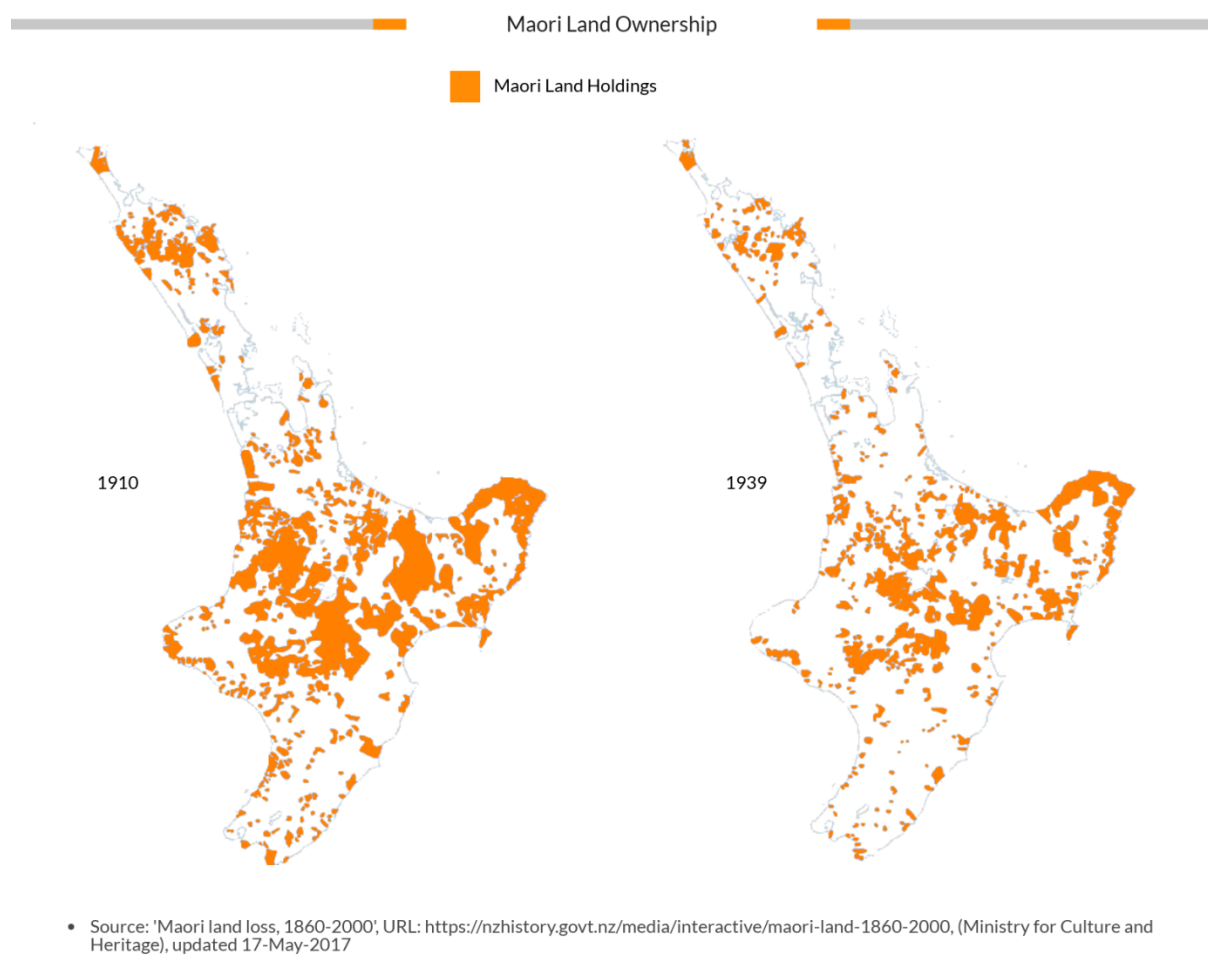
Conclusion

There is no doubt that Māori health initiatives were consistently underfunded in the first decades of the twentieth century. There is also no doubt that the haphazard administration of Native policy and Māori health policy during this period not only contributed to that situation but created an environment of such uncertainty that Māori were unable to gain any real traction in their attempts to exercise autonomy via government institutions. The beginning of the twentieth century marked a concerted attempt by Māori to create autonomous spaces within the government system to develop and apply a system of oranga that combined the principles of oranga with western health practices. The 1900 Māori Councils and Māori Land Administration Acts were state sanctioned autonomous vehicles. This pattern of making concessions to Māori calls for control over their own wellbeing—oranga—was a balancing act weighed up against the expectations of a Pākehā majority and the state’s own need to

retain power and stability. It is argued here that oranga and the principles that formed its foundation were irrelevant if not undesirable to the government. Oranga was completely off the government radar. What was on the radar was the assimilation of Māori into a western health system.

New Zealand Population





Chapter 5. A Healthy Equality? (1945–1975)

In 1963, a North Hokianga elder, Pakihi Peita, attended a Department of Māori Affairs review of his whānau farm. He hoped to establish his son John (JP) on it, but their farmhouse could not accommodate everyone. Pakihi sought some assistance. The full outcome of his hearing is recorded as follows:

Commissioner Bell had told him [Pakihi Peita] to leave the son the house and go to town. For sentimental reasons he had not been able to do this. However, he was now prepared to leave if son would come back on farm. The Committee told Mr Peita that the economics of the proposition were very doubtful. Home block of 30 acres, good little farm but the other property not dairy country. The boy would be better advised to get a job as a shepherd somewhere else.

In the end, JP made a deal with his father. He explains their arrangement:

I said, ‘dad, I’ll go’. I didn’t go far away, just to Broadwood. I was the [shepherd] manager at Broadwood’s Lands and Survey. I stayed there for a few years, and then I went to Auckland. He [Pakihi Peita] cried. He didn’t want me to go to Auckland. I said to him, ‘Papa, you stay on the land. If you die before me, I’ll be back as soon as you close your eyes, I’ll be back.’¹²

Leaving the kāinga became the only viable means by which oranga could be maintained by Māori during this period. It was at once an active attempt on the part of Māori communities and their whānau to care for each other and to safeguard their whenua—their tūrangawaewae. In the first half of the 20th century, infectious diseases were the leading cause of death for all. Changes in the ability to avoid and withstand infection were the prime factors in reduced mortality. Nutrition and public health measures were the most important disease-fighting factors in the reduction of mortality during this period. Mortality decreased at a relatively constant rate of one percent per year between 1900 and 1940 in the United States (Cutler & Meara, 2001, p.2) and Pākehā mortality in New Zealand was among the lowest in the world (Pool, 1977). While mortality decline had been relatively continuous over the 20th century, the ethnic distribution of mortality decline was not so. Māori suffered 50 percent higher rates of mortality than their Pākehā neighbours (Pool, 1977, p.146). It would appear that Pākehā benefitted the most from the improved sanitation, public health, and nutrition and supplements measures. Despite Māori representing six percent of the total population during this time, health improvement failed to reach them.

Meanwhile the state supported the urban-ward movement of Māori as a means of fully assimilating them into ‘mainstream’ of New Zealand society. In the name of responsible citizenship, Māori would fill the job shortages and the land they freed up would be acquired for the purpose of putting it into full production. The state aimed to effect much of these changes through the Māori Social and Economic

¹² Williams (2015)

Advancement Act of 1945, policies developed from the Hunn Report of 1961, and a slew of Māori land legislation culminating in the Māori Lands Act 1967.

Pool (1991, p.133) describes the Māori population as undergoing ‘a transition in every demographic variable’ and being ‘subject to massive ‘shock’ in the space of 40 years, from 1945 to 1966. This included a decline in mortality due to an ‘epidemiological transition’ from diseases affecting the young: infectious, tubercular, respiratory, and diarrhoeal diseases, to diseases affecting older people: long-term conditions (or, in Pool’s terminology, degenerative disorders) cardio-vascular, cerebro-vascular (strokes), and cancer. An increase in fertility and a youthful population structure also marked the years from 1940 to 1966. By 1966 the proportion of urban Māori 0–4 year olds was similar to rural Māori 0–4 year olds (Pool, 1991, p.160).

Indeed, good gains in Māori health and its indicators were made during this period, but it will be argued that health equity and the broader aim of ‘universal welfare’ in New Zealand not only failed to transpire, but also became one of the government’s rationales for not supporting the Māori War Effort Organisation which was ready and willing to make it happen. The organisations that did emerge were nevertheless instrumental in pushing a Māori cultural agenda at a time when oranga was under considerable pressure and Māori in both urban and rural Māori communities were struggling to meet the basic housing and health needs of their whānau. This chapter also explores the importance of medical interventions and the swiftness with which medicalization was accepted by Māori. The positive effects on mortality during an era of infectious disease need to be viewed alongside the shift in power to secure health within a biomedical framing. The latter undermined generations of oranga practices and knowledge within a few years.

Urban Migration

From the 1930s, Māori began leaving their tribal communities, places that had informed their identity for generations. Migration was not new, but by the mid-twentieth century men, women and children—entire whānau—began heading to urban areas ‘in response to assimilationist state policies, a faltering rural economy, and the aspirations of a growing population’. They left with ‘a sense of uncertainty, even finality, that had never before been imagined’. Their survival as a people and the future of their whenua depended on it (Williams, 2015, p.39). New Māori strategies for survival clashed with a range of government policies promoting the economic and cultural assimilation of Māori people. Under the banners of ‘modernisation’ and ‘equality’, the government made some attempts to arrest the inequities Māori were living with in both rural and urban areas. But the broader paternalistic, ethnocentric and culturally oppressive ideas informing such initiatives continued to permeate the politics of Māori health and undermine oranga.

Māori urban migration can be viewed as a proactive Māori response to managing rural poverty, unemployment, and a lack of basic housing, educational and health facilities. The government’s failure to invest in the development and welfare of rural Māori communities at that time encouraged if not pushed Māori to move to the cities and raises questions about the long-term and much broader impact of that policy on

Māori cultural wellbeing. To what extent, for example, did Māori cultural and tribal development suffer and how did the government's encouragement and funding of the physical and cultural assimilation of Māori into a mono-cultural urban wage-based economy impact on Māori health and wellbeing?

Māori migration peaked in 1966 with 62 percent of Māori living in urban centres, nearly a third of whom were living in Auckland. This partly resulted from a rapidly increasing Māori population as immunity to disease strengthened, concurrent with increasing birth rates and decreasing infant mortality. This had occurred amongst rural whānau living on limited land and limited opportunity to develop land despite schemes aimed at this (Anderson et al., 2014, p.395). Government restrictions on rural housing support was eventually coupled with formalised state support from the Māori Affairs Department for urban migration. Māori would not be shifted into pre-planned ghettos but be physically integrated into Pākehā neighbourhoods. This 'pepper-potting,' which was articulated by the state in the Hunn report of 1961, was to ensure optimal exposure to western modes of living.

Regardless, Māori migrated with their cultural luggage to the towns and cities where a dynamic of mutual support between Māori rural and urban communities developed (Anderson et al., 2014, pp.397–398). The ways that Māori exercised agency meant that aspects of Māori urban communities ran counter to integration policies. Rural Māori communities were sustained by Māori urban migration and remained for migrants the cultural home places to which they remained anchored. The sustainability of tūrangawaewae was maintained by urban Māori communities, and vice versa (Anderson et al., 2014, p.398).

Indeed, Māori migrants made their own decisions about whether or not to engage or disengage with state policies at this time. They made decisions as whānau and communities, taking into consideration the particular roles and needs of family members. These were 'whānau-driven migrations' that not only aimed to protect tribal lands, marae, homes, farms and every other resource, but also whānau members settling in the cities. By offering social support whānau were protective of new migrants, while also reducing their exposure to racial discrimination. Māori agency existed and Māori were optimistic for their futures, but that optimism came from a deep desire for a better future. In 1945, the majority of Māori were experiencing poor living environments. Up to 80 percent of Māori were living without basic amenities such as hot water, flushing toilets, baths or showers, or electricity (Pool, 1977, p.37). That better future would come with post-war full employment and access to Māori Affairs housing. But it would be a brief reprieve. As the following chapter will illustrate, by the 1970s an economic downturn would herald the beginning of a downward slide for Māori, both urban and rural.

National Government Policies

As Williams writes, 'the relentless drive for Māori assimilation continued when the National government (1948–57) came into power and bolstered the policy of assimilation in line with an urban future for Māori' (Williams, 2015, p.72). It came into power 'without any Māori MPs and without any previous interest or conspicuous

expertise in Māori Affairs'. Thus, the Welfare division of the DMA, Tipi Ropiha (a long-standing public servant and Secretary of the DMA under Corbett) and the MWWL assisted Corbett in his portfolio. The advice they gave and the policies they developed attempted to provide Māori with much needed support in both urban and rural areas. At one point this even meant finding Māori ways to make Māori land productive in a fast-changing economic environment.

Corbett and Ropiha marked out land development and title reform as their central goal. 1953 saw the passage of the Māori Affairs Act that sought to establish profitable farms from those areas considered uneconomic. The idea was to 'purge' Māori land of multiple owners through a process called conversion. This allowed lands considered uneconomic to be vested with the Māori trustee. This could be controversial where succession, partition or consolidation was taking place because land deemed 'uneconomic' could be vested compulsorily. Trustees could then on-sell the uneconomic shares to those individual Māori who were looking to build up significant land interests. As with the consolidation schemes though, problems soon emerged with the complicated bureaucracy needed for administration. In addition, trustees found great difficulty in their ability to on-sell uneconomic interests. Instead trustee land portfolios became stacked with interests that nobody was prepared to pay for and so in many cases 'the Crown became a major shareholder in some large blocks of Māori land, an 'absurdity' that enabled the Crown to partition out its newly and controversially acquired interests' (Anderson et al., 2014, p.390). Conversion was opposed by the Māori MPs who saw it as merely another process separating Māori from their land, from their Māoriness (Anderson et al., 2014, p.390). The view of the government though, was that conversion held an importance well beyond dealing with uneconomic land. The 'sentimental attachments' Māori had to land, had to be severed for them to become productive modern citizens. For Māori though, connection with the whenua maintained their identity (Anderson et al., 2014, pp.391–392). However, connections to the whenua and how one could live of it continued to change.

The Demise of Farming, Māori Land Development Schemes

From the mid 1930s the first Labour government changed the nature of the Māori land development schemes whereby Māori farms became individual business enterprises consisting of contractual obligations (mortgages and loans) between the state and Māori farm 'units'. Williams argues that 'the individualisation of Māori land titles and farms eroded collective forms of economic development and thus undermined leaders' efforts to develop the local economy. Even worse, the government's drive to increase the size and production of farms led to a reduction in the number of actual farms. People, whānau, were becoming superfluous to their own whenua (Williams, 2010, p.50).

Within the land development schemes, communities still relied on a cultural economy that provided a buffer against extreme poverty. As Hirini Kaa notes, whānau in the Ngāti Porou region remained committed to seeking economic deliverance from a system of land utilisation that had disadvantaged them from the beginning. Ultimately, family farms were just one part of a Māori economy made up of waged and farm incomes, state welfare benefits, the ongoing utilisation of local natural

resources, and the pooling of personal incomes for community-based amenities, such as marae, churches and schools (Williams, 2010, p.50).

Post-War Policies and Māori Autonomy

The Māori War Effort Organisation (MWEO)

The MWEO was the closest Māori got to truly leading tribally autonomous lives in the twentieth century (and arguably from the 1860s). The organisation was set up to assist with the war effort but ultimately also engaged in much community welfare work and organisation. The MWEO consisted of around 300 tribal committees operating independently of the government to fundraise, rally wartime support, and engage communities in welfare or cultural revival activities. Harris writes:

Working locally meant that those involved in the war effort became aware of a range of community needs, including the problems associated with increasing Māori migrations to the cities, and keeping tribal marae alive and relevant. Community energies generated for the war effort [were also used to] “fix up the maraes, and buy things for the schools”. At Wairuru marae, the women made new mattresses and bed linen, and ‘had the best-kept marae for miles’. At Raukōkore, the tribal committee organised each farmer in the area to identify a cow for the marae, ensuring a supply of meat for tangihanga and other hui. This important community development work, which often included welfare assistance, occurred not only outside the boundaries of the MWEO’s core functions but also independently of the Native Department’ (Anderson, et., al, p.377).

Towards the end of the war, Māori leaders pushed for governmental recognition of the ‘self-administration and discipline’ their people had demonstrated in contributing to the war effort. In arguing that the committee system should supersede the official state agency for Māori, they envisaged vibrant tribally-based committees operating at community or marae level and reporting to superior, but equally autonomous, bodies (Hill, 2004, pp.12-13). However, the government was not prepared to endorse the committees as autonomously presented. Instead, it passed the Māori Social and Economic Advancement Act 1945, which transformed the MWEO committees into quasi-state entities that assisted with policy development and implementation for the Department of Māori Affairs (Williams, 2015, p.71).

Under this Act, tribal committees could create and administer health by-laws, as well as elect the Māori wardens who would enforce them. The Minister was authorised to match pound for pound the fundraising efforts of tribal committees. Māori were long adept at fundraising and this new incentive provided further impetus (Anderson et al. 2014, p.386). Access to departmental information via the tribal committees attracted community members to meetings. Sometimes departmental officers attended meetings to answer questions about the application process for Justice of the Peace and warden nominations, marae and education subsidies, and housing loans. However, the amount of financial assistance available through the committees was limited and the bureaucracy involved meant that community development was frustratingly slow. Still, the overall task facing tribal committees remained daunting; to preserve and revitalise Māori culture while simultaneously moulding their people into good and economically productive citizens (Anderson et al., 2014, pp.386–387).

The effectiveness of these committees was variable. By 1958 only one tribal executive out of seventy-six had actually passed a health by-law. So much depended on local circumstance and it was not the case that tribal committees merely toed the line of departmental policy. The desire for genuine local authority persisted and so Māori were engaged in a kind of balancing act that would characterise political and social activity down the decades (Anderson et al., 2014, p.387).

The Prime Minister and Minister of Māori Affairs, Peter Fraser, espoused a Māori policy of ‘full equality’ and the idea that urbanisation would ‘not necessarily be detrimental to Māori if it occurred within the “social and economic structure of New Zealand”’ (Williams, 2015, p.71). Fraser worked toward that goal by extending farm training to include young Māori, for example, and by addressing the plethora of challenges facing an increasingly urban Māori population. Now, more than ever, the influence of the Māori Affairs Department could be felt at a whānau level. Whānau would engage with the department for educational grants, job training, mortgages, land development, employment assistance and support when moving from the rural to the urban. Harris and Williams argue that the scope of influence was wide so by the end of the 1940s and onwards the Māori Affairs Department had become ‘probably the most important point of contact between Māori people and Māori Affairs, and the most effective means of implementing the legislation that framed post-war Māori policy’ (Anderson et al., 2014, p.385).

However, Māori MP’s were critical of the race politics underpinning Fraser’s definition of equality. They argued that ‘Labour’s Māori policy reflected a form of ‘equality’ that was characterised by assimilationist ideals, which at best would dilute the equality and at worst render it null and void’ (Williams, 2015, p.73). The Rātana members of Parliament wanted to protect Māori cultural identity, as opposed to tribal identities, while some tribal leaders did not want to lose tribal members to the cities. Māori MPs believed that the autonomy of tribal committees was compromised within the department and there was unease about the possibility of the government using Māori urban migration to accelerate a policy of assimilation. Equality for Māori, whether Māori liked it or not, was becoming viewed as a goal that could potentially be attained through Māori assimilation/participation in a capitalist economy as individual citizens (Williams, 2015, p.72).

The state’s financing of Māori land development and Māori housing attracted ‘criticism from Pākehā because of what they saw as preferential treatment for Māori’. Indeed, Fraser was aware that he was walking a fine line in ‘the Pākehā opinion stakes, with the political opposition and many Pākehā bemoaning a Labour government that pandered to Māori’ (Williams, 2015, p.72). Critics blamed the DMA’s poor management of Māori land development for the dreaded ‘drift’ of Māori to the cities. In 1949 the ‘National Party sat in opposition and suggested setting up a ‘trust organisation’ to farm Māori land on the basis that ‘young Pākehā would farm Māori land if young Māori were not prepared to do so’ (Williams, 2015, p.72). Such views highlight how out of touch with Māori realities Pākehā New Zealand was at that time. The land development schemes were no longer a viable means for an increasing Māori population to support itself.

Māori Women's Welfare League

Māori women came to the fore of Māori health politics during this period with the establishment of the Māori Women's Welfare League in 1951. Although the League's objectives reflected the government's assimilative policies, in practice it defended and reinforced Māori approaches to oranga at a time when many of its foundations were under attack. The League's concerns were important and urgent. Their focus was on family, women, children, health, housing, education and justice. As with the tribal committees though, the League was financed into existence through Māori Affairs, and as such have had to perform the same balancing act between Māori values and departmental integration policies (Anderson et al., 2014, p.394).

At its inaugural meeting, some 300 members 'debated and produced seventy-two resolutions that reflected wide-ranging concerns in health, housing education and justice'. The League collaborated with, and relied on the government for support, but often it had to be on the League's terms and directed toward their priorities. Indeed, the history of the League clearly shows that its membership was constitutionally aligned with the government's integration policies of the day. In fact, the League worked closely with the Department of Māori Affairs and its Māori welfare officers. However, the women guarded and exercised their autonomy as a Māori women's collective, and they were not swayed by government opinion or pressure. In practice the league 'is remembered for assaulting the ears of government' (Anderson et al., 2014, p.394).

Housing

The government's Māori housing programme was expanded after the war and came under intense scrutiny by the League who took issue with the whole process, from how houses were designed to the way mortgage repayments were structured, and everything in between. Housing was the focus of the League's initial efforts, which indicates how poor housing conditions continued to be for Māori during the 1950s. The League challenged the government regarding the situation where there was high demand for Māori labour in Auckland, coupled with an inability to secure decent accommodation or any accommodation. In order to provide evidence of the situation, the League conducted a survey that found Māori living in dismal conditions, the more severe cases involving families crammed into tiny, cold, and sometimes condemned accommodation. The League argued strongly that more state rentals be reserved for Māori, something which Corbett never conceded despite acknowledging that Māori often could not afford to buy a home (Anderson et al., 2014 pp.394–395).

The deep impacts of housing policy on oranga during this period are often limited to illustrating the racism inherent to the 'pepper-potting' policy and to the excruciatingly slow response of the government to urgent Māori housing needs. Williams, however, argues that the ways in which the state set up the qualification for housing, based on the nuclear family model, actually adjusted the way Māori people lived, with whom they lived and some of their customs. The customary practice of atawhai, for example, which provided inter-generational and extended-whānau wrap around care for tamariki, was most at risk. She writes,

In defining what was and was not a family, the state turned children into objects that had to be retained by parents in order for them to qualify for a home. Evidence exists of parents requesting the return of their children from back-home in order to fulfil the eligibility criteria, and of deals being made with grandparents about the length of time children would be retained in Auckland before being sent back-home. Conversely, some childless couples benefited from the practice of atawhai in that they could qualify for a home if the arrangement was legally registered as an adoption (Williams, 2015, p.153).

The Hunn Report

The Hunn Report of 1961 was a sweeping assessment of the Māori ‘situation’. It investigated among other things population change, land settlement and titles, housing, health, education, and even intermarriage. Overall, the report suggested that considerable improvements had been made, but that significant differences between Māori and Pākehā continued to exist. Māori life expectancy, university enrolments, housing and employment were lower than Pākehā rates, and in areas like crime and infant mortality Māori rates were higher. Despite steady improvement since the early 1900s the infant mortality rate for Māori was twice that for Pākehā, life expectancy roughly ten years lower, and an estimated 30 percent of Māori lived in ‘grossly overcrowded’ conditions’ (Anderson et al., 2014, p.401).

Hunn’s proposed solutions to these inequalities align with this report’s analysis of government impacts on oranga and Māori health inequities. To Hunn, the best future for Māori lay in discarding the most backward aspects of their culture—tribalism (whakapapa and whānau) and attachment to their land (whenua)—and ‘gradually eliminating’ special legislation that affirmed cultural differences between Māori and Pākehā, or in other words, integrating Māori fully into the social and economic of New Zealand society so that they could gain full equality. The process of integration was viewed as a natural process which the state would simply support. Some Māori had already ‘detrribalised’, most were still living in both Pākehā and Māori cultural worlds, but a stubborn percentage the ‘most retarded Māori’ were still ‘complacently living a backward life in primitive conditions’ (Williams, 2015, p.220). The eighty-four conclusions in Hunn’s report, much of which became government policy, sought to affect the full integration and urban movement of Māori by tightening Māori land legislation, and through a range of other methods (for example, Māori relocation and housing policies).

At their best, the policies were paternalistic and, at their worst, amounted to social and cultural engineering (Williams, 2015, p.84). The New Zealand Māori Council was established after the passage of the 1962 Māori Welfare Act, as well as the Māori Education Foundation (Anderson et al., 2014, p.410). These were to be the vehicles for accelerating ubiquitous mainstream policies (Anderson et al., 2014, p.407). One effect of this was to disrupt the relationships that had formed between Māori communities and the Welfare Division. Overtime this division would focus less on communities and more on individuals and their families, in accordance with the general push for integration (Anderson et al., 2014, p.408).

The assimilation policies of the ‘Hunn’ era were already in effect throughout other parts of the world. Indigenous people, who were exposed and at the mercy of similar policies were experiencing relatable disruptions at the hands of their governments and,

like Māori, indigenous health and oranga were strikingly similar (Williams, 2015, pp.86-87).

Hunn and Oranga

The two most threatening pieces of legislation to oranga during this period emerged from the Hunn report: the 1962 Adoptions Amendment Bill and the Māori Affairs Amendment Act 1967. The former sought to mainstream Māori adoptions by transferring official responsibility from the Māori Land Court to the Magistrate's Court. This bill was supported by the NZ Māori Council despite internal and external (the MWWL) opposition (Anderson et al., 2014, p.411).

Tamariki atawhai

Despite state attempts to curb if not stop the practice of atawhai (also commonly known as whāngai), Māori continued this customary practice well into the mid-twentieth century (and to this day). In 1901 the Native Land Claims and Adjustment and Amendment Act made it necessary to formally 'register whāngai placements in the Native Land Court to qualify the child to succeed to lands of their whāngai parents'. The Act also legalised the adoption of children outside of the kin-based network. Further changes were made when the Native Land Act 1909 prohibited customary whāngai practices. Instead, formal adoptions needed to be legally registered through the Native Land Court. As McRae and Nikora note, Māori continued to whāngai children, but at 'the risk of whāngai not being able to legally succeed to land'. By 1915, the concept of 'secrecy' dominated adoption laws, but some allowances were made for Māori values with Māori Land Court adoption hearings remaining open and published in the Kahiti (Māori Gazette) and the New Zealand Gazette.

The 1955 Adoption Act and its 1962 Amendment further tightened the principle of secrecy. The legislation created 'closed' adoptions that undermined the transparency of whāngai practices as 'somehow detrimental to the child and their whāngai parents'. The whāngai practice fostered whakapapa connections, but the Adoption Acts of this period effectively cut those connections. Cutting those ties was 'further facilitated in the 1960s and 1970s when Māori children deemed to be living with 'unfit' parents were placed with Pākehā families or institutionalised. This form of child 'care' was consistent with assimilative policies that promoted the Pākehā nuclear family over whānau-based systems' (Karyn Okeroa McRae and Linda Waimarie Nikora, based on Suzanne Pitama's research, in Williams, 2019, pp.65-66).

Given the culturally alienating bureaucracy of New Zealand's social welfare system, and the risk of losing children to it, it is unsurprising that the practice of atawhai continued under the official radar in Māori communities. For Māori, the practice of atawhai was never about taking ownership of a child. As McRae and Nikora explain, it was about 'establishing, nurturing and cementing relationships between individuals, families and broader relational networks (Williams, 2019, p.66). It can also be argued that the practice of 'enforced child adoption' is at its worst, an extreme example of assimilation. Similar practice was already occurring with other indigenous cultures (e.g., Australia, Canada and some parts of America). They already understood the dehumanizing experience and effects of children being "taken' from their homes and

placed in ‘proper’ Christian homes in order to learn work skills and the Christian faith. These ‘stolen generations’ lost their language and culture and caused tremendous community and family disorganization’ (Neilson & Robyn, 2003, p.37).

Whānau—The Medicalisation of Childbirth

Alongside successful public health initiatives were the beginnings of a medicalised health care system. Medicines in the form of antibiotics, including penicillin, the doctors and nurses prescribing them, and also the hospitals that housed them fast became the answer to fighting the devastation of the past century. The government’s policies had already begun stripping Māori customary practices and cultural behaviours away from Māori and now rongoā Māori was swapped for pill packets and syringes.

In terms of childbirth, prior to the establishment of the 1904 Midwives Registration Act, Māori birth was a ritual performed within the safety and support of Te Ao Māori (Tikao, 2014). The knowledge of birthing and whakapapa passed down through oriori (ancient chants) even before conception, laying before the baby their future. These traditions and knowledge, both practical and spiritual, helped to guide good birthing outcomes for Māori (Tikao, 2014). The Midwives Act (1904) provided for the registration of midwives and gave to the establishment of state maternity hospitals and for the training of midwives within them. At this time there was no official record of data for Māori birthing and giving birth within these facilities was not free, so the majority of births were performed at home. For the next 30 years Māori continued to practice tāpuhi (midwifery practice) within their homes while Pākehā birthed in institutions. By 1938, 87 percent of Pākehā babies were born in institutions, but only 17 percent of Māori births were in hospital (Clarke, 2012, p.96).

By 1925 the Nurses and Midwives Act formalised courses of training and approved the institutions of training and hospitals. The Act also provided a penalty for persons not registered carrying out the duties of a midwife or maternity nurse (Maclean, 1932). Harris (2001, p.7) has captured the birthing experience of two Māori women from that time.

It was simply too difficult and time-consuming to get to the local hospital across the harbour. It meant travelling some forty kilometres, either by private car or courtesy of the daily cream truck. Pregnant mums often did not call for assistance until the baby was close to arriving, so there simply was not time to get to hospital. It seems to have been completely usual for a local person to assist during childbirth in isolated communities like Mangamuka (Harris, 2001, p.7).

At the same time advancements were being made within the medical field in science and technology, including pain relief. Women were encouraged by their doctors to give birth in the safety of a hospital and by 1962 the rate of Māori hospital births had caught up with the Pākehā rate, and 95 percent of all New Zealand babies were born in a hospital setting. By introducing the Nurses Act 1971, Parliament then effectively ended any remaining autonomy enjoyed by tāpuhi and midwives by making it an offence for them to carry out ‘obstetric nursing’ (Sweetman, 2013, p.12).

Whenua Māori—‘Not one more acre’

The Māori Council may not have foreseen the long-term impact that the Adoption Amendment Act would have on whānau, but it understood and firmly opposed the loss of whenua via passage of the Māori Affairs Amendment Bill 1967. Even so, its opposition had no impact on the government. Hunn’s proposal to transfer more Māori land into individual title eventually proceeded under the Māori Affairs Amendment Act 1967, despite near universal opposition by Māori. Under this Act, lands vested and reserved with the Māori Affairs Department and with Māori Trustees could be converted into freeholdings. Where Māori land was owned by four or less people, it was to be converted compulsorily into European land (Anderson et al., 2014, pp.412–413). The government had alienated every sector of Māori society (Anderson et al., 2014, p.413).

In 1970 a Young Māori Leaders Conference was convened at Auckland University. It saw the stirrings of an emboldened and outraged generation of young and educated Māori who were unwilling to accept the racism, cultural oppression, and inequities that their forebears had laboured under. Ngā Tama Toa was one such group. Concerned about land and language loss their tactics were direct and confrontational as they challenged Pākehā society to rethink the perception of harmonious race relations and their history in New Zealand. Being challenging and confrontational was not new to Māori politicking, but now the foundations of New Zealand identity were being challenged. The idea that New Zealand had the best race relations in the world and the idea that New Zealand was an egalitarian society were exposed as myths (Williams, 2015, p.2017).

Concern and anger over the historical and ongoing loss of Māori land was articulated via land occupations and the Māori land March of 1975. Whina Cooper led the land march which started in Te Hāpua in the North and ended on the steps of Parliament in Wellington. ‘Not one more acre’ was the battle cry and the march aimed to have all legislation that threatened Māori land removed (Anderson et al., 2014, p.418). The Ratana MP and Minister of Māori Affairs, Matiu Rata, responded quickly to the negative response from Māori to the Māori Affairs Amendment Act 1967, and began preparing the Māori Affairs Amendment Act 1974, before the Land March even began. This waived the provisions of the 1967 Act that empowered the Māori Trustee to acquire uneconomic land interests compulsorily. Also, Māori owners of land under European title could apply to have it converted back to Māori title. Next, Rata pushed for the Treaty of Waitangi Act 1975. That Act led to the establishment of the Waitangi Tribunal which convened in 1977 (Anderson et al., 2014, p.419).

At this point the Tribunal was empowered to investigate claims by Māori of breaches to the Treaty, but not retrospectively. Politically, Rata had achieved a lot in a short time period, though it would not be enough to deter Whina Cooper and the marchers from their kaupapa. The Land March began and eventually 40,000 people joined at different points on the trek south. When the march arrived in Wellington the Prime Minister Bill Rowling was presented with a signed Memorial of Rights as well as a petition containing 60,000 signatures (Anderson et al., 2014, p.420). However, the Tribunal was not without its critics. A major aspiration of Māori was to see the

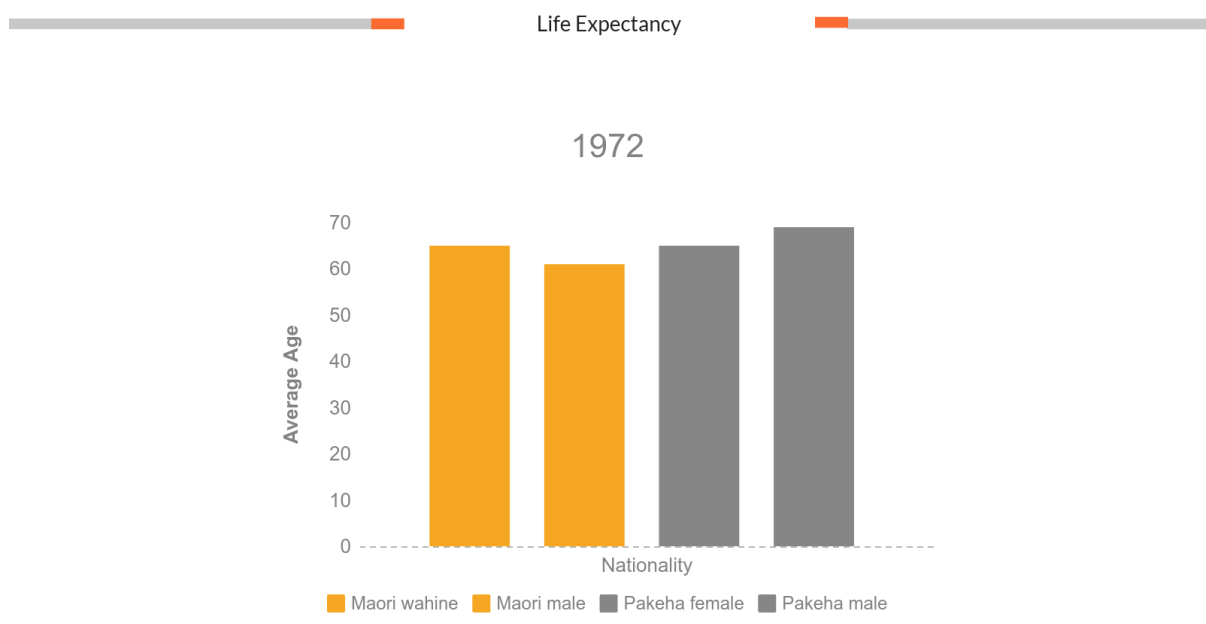
entrenchment of the Treaty of Waitangi into the ‘jurisdiction framework’ of New Zealand. The Treaty of Waitangi Act fell short of this as well (Anderson et al., 2014, p.421).

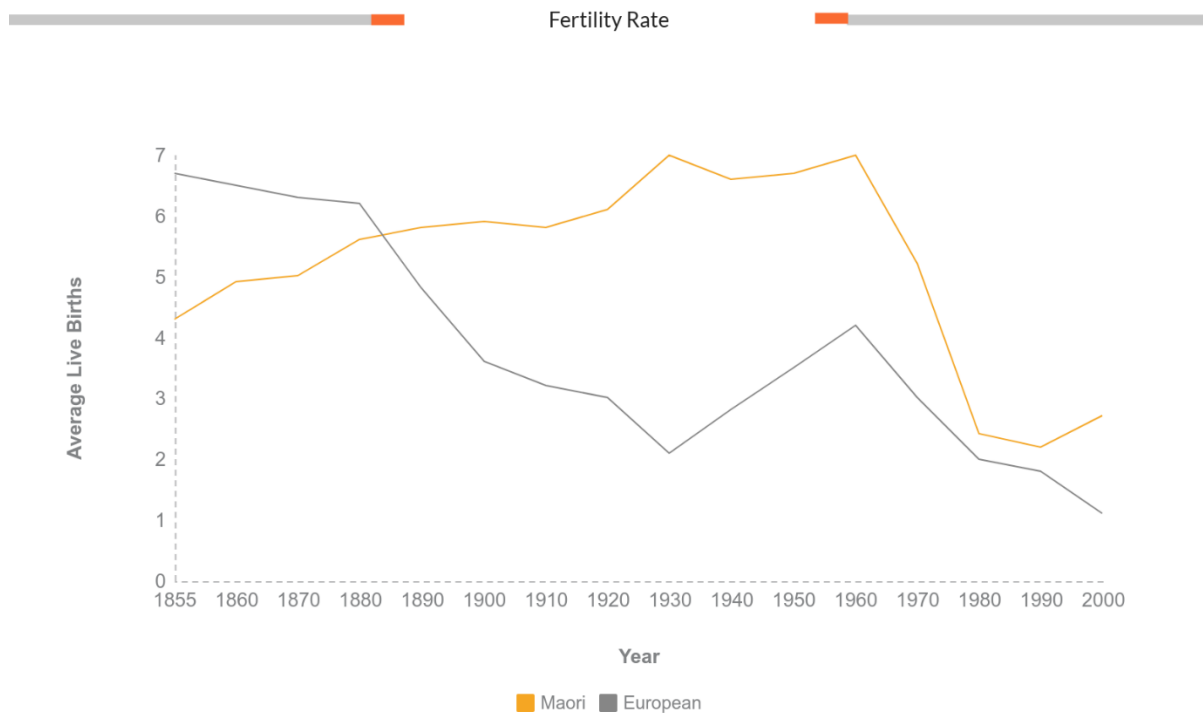
The disparities which contributed to the drive of Māori activism told an alarming story about Māori health inequities. As Harris and Williams point out, ‘in 1972 the life expectancy of Māori males and Māori females was just sixty-one years and sixty-five years respectively’. This was a good improvement on statistics from the turn of the century, but ‘compared poorly with Pākehā life expectancy rates of sixty-nine for males and seventy-five for females. The disparities were clear, with Māori disproportionately represented among those suffering a range of chronic illnesses’ (Anderson et al., 2014, p.432).

Infectious diseases, especially tuberculosis and typhoid fever, had remained more prevalent in Māori communities up to the mid-twentieth century but between 1955 and 1975 the main cause of Māori deaths had shifted to ‘accidents, heart disease, cancer (especially lung cancer), and both respiratory and metabolic disease’ (Anderson et al., 2014, p.432). Accompanying these poor health statistics were ‘alarming social statistics that revealed excessively high Māori rates of incarceration, unemployment, educational failure and hospitalisation’ (Durie, 2009, p.245). Equality had never been part of the narrative of health, but Māori pushed and would continue to push to achieve it.

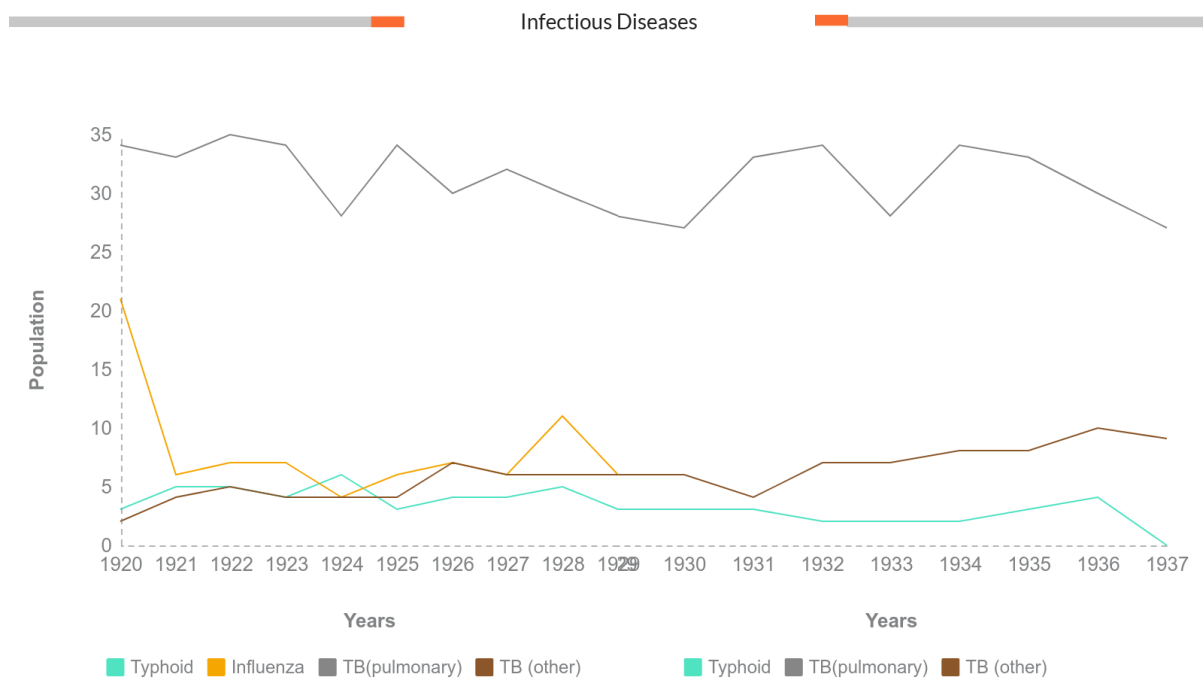
Conclusion

The immediate post-war years saw major demographic changes occur in te ao Māori. Those changes brought cultural pressures as well as cultural benefits, given the pressing economic environment of the time. Māori not only negotiated their connections to old and new home places, but they were forced to find spaces in the city where they could maintain cultural practices and values. All the while, Māori also negotiated assimilation policies which were accelerated by the governments during this time. Māori children and the whenua were placed at risk. Oranga – maintaining the whenua, whakapapa and whānau – was partially achieved, but it was tenuous and dependent on good incomes and access to better housing. By the 1970s, cracks were beginning to appear and both social and health inequities were becoming visible. Although Māori were able to control some of the changes that occurred during this period, they would find themselves protesting much more over the next decades.





• Source: Te Ara. Retrieved 14 August 2019 from: <https://teara.govt.nz/en/graph/30192/fertility-rates-maori-and-non-maori-1844-2015>



Chapter 6. Healthy Partnerships? (1976 to 1992)

A formal meeting was called to discuss Nan's care in 1992. Although fiercely independent she.. needed someone to help her full-time with daily meals and personal care. It was a difficult whānau meeting at which it became clear that Nan did not want to come to Auckland (she was not present at the meeting), and no-one at that time could go back-home [to our papakāinga in North Hokianga] to look after her. Everyone had commitments in Auckland—work, health issues, homes, young families. There was no work back-home and anyone moving back to the area was declined social welfare benefits. Ultimately, I visited Nan and she agreed to let me look after her in Auckland for a while. Upon reflection I was ill-equipped to care for her [and] there was a lack of information about professional support. Other whānau members visited regularly, but Nan was reluctant to live anywhere else. It isn't surprising. I let her smoke cigarettes in the house, and do and eat anything she liked. She often requested the great-mokos dance and sing for her and she talked on the phone to relations for a good part of the day. Eventually, though, the time, energy and skills required to ensure she was receiving adequate physical care led to her going to stay with her son.... By now he was in his 60s and [his wife] was unwell. They too struggled. Nan's health had been slowly deteriorating and eventually [she was placed in] Carnavron Hospital, close to my home in West Auckland. Nan did not like it at Carnavron and I did not like her living there. The patients and staff were nice enough, but she was the only Māori resident and the environment and routines were culturally alienating and stifling. We all rationalised that she needed proper medical care, and that was right. But the fact that she was in a 'hospital', not an old people's 'rest home', did little to shift my belief that we, her whānau, were failing her. She wanted to go back to the papakāinga and I feared she was losing her mind. The whenua and papakāinga was always about more than having a place to live. Being home also provided a much broader sense of oranga or wellbeing that nourished Nan's worth, being and identity. Good physical care was almost pointless while Nan was forcibly separated from the papakāinga. It was a distressing situation and, in my view, at that time, there was no solution to it.¹³

In 1992, the dual narratives of oranga and Māori health inequities converged and exploded in a way that is difficult to describe without an intimate whānau narrative. While Māori academics, health professionals, politicians and community leaders, elders, workers and activists kept pushing forward with demands for better and culturally appropriate health care, the reality for whānau trying to live or survive in their communities was stressful and culturally soul-destroying. Four generations of Matutina's whānau were caught in a system that marginalised them and the value of whakapapa, whenua and whānau—oranga. The decision to place a kuia in a rest home became an understandable (within the context of this report) narrative of whakamā that will be inherited by future generations of Matutina's whānau. You have to live the trauma of colonization to retell it.

The time period from 1976 to 1992 witnessed the decline in Māori wellbeing and a steady increase in Māori political activism. Harris and Williams (Anderson, et al., 2014, p.88) describe a 'narrative of trying socio-economic conditions in a long history of colonization-induced inequities and marginalisation consistently underwritten by Māori stories of resilience and fortitude, persistence and insistence'. Land marches and protests

¹³ Williams, M. (2019, pp.73-74)

were clear signs of Māori wanting to retain and reclaim land. Legislative changes promised by the Honourable Matiu Rata, MP, supported this, including the legislation to establish the Waitangi Tribunal in 1975. Changes to support Māori aspirations were however taking place within the context of broader economic reforms that began in 1984. These reforms would see steep rises in Māori unemployment and just as steep declines in Māori household incomes. These, combined with the poor state of Māori housing, contributed to a decline in oranga and rise in the sphere of health inequities.

The devolution of government services, including health services, occurred within the context of reduced government spending and the replacement of the service delivery function of the Department of Māori Affairs with the policy advisory agency Te Puni Kōkiri (Harris & Williams, 2017, p.450). Māori leapt at the chance to deliver health services within their communities, particularly as many knew that ‘mainstream’ (i.e., government) health services were failing to provide accessible (i.e., available, culturally responsive, quality) health care for their people (Pipi, et al., 2003, pp.6-7). Indeed, these were the years when women’s health groups became a political force and alternative health options became more acceptable. Māori health workers became more vocal and organised. The National Council of Māori Nurses was established, and Māori doctors met to discuss the state of Māori health. There were reminders from kuia and kōroua that Māori wellbeing was the result of a complex set of relationships that included social, economic, political, cultural and spiritual factors. The relevance of these factors, together with culturally appropriate practices, was discussed. Models of health that reflected Māori world views and their historical context were re-examined and promoted (Pōmare et al., 1995, pp.25-6). These were the decades of give and take, with promises of partnership, devolution and self-determination that were only partly fulfilled by governments reluctant to share power.

This chapter traces how Māori fought for oranga, to control its definition, administration and delivery to iwi Māori between 1976 and 1992. It summarises how the principles of oranga underscored Māori protest and went on to shape the first Waitangi Tribunal claims and the emergence of autonomous Māori health programmes around this time. The chapter then focuses on how neo-liberal politics and legislation saw the emergence of a bicultural health system and some opportunities for Māori to exercise autonomy within the health frame it provided. Prior to concluding, the chapter discusses the themes of disability and mental health, primarily within the context of how the narrative of health inequities continued.

Dire Times: Oranga and Māori Health Inequities

A range of national and international factors converged to impact on oranga and Māori health inequities in the late 1970s and 1980s. Britain had joined the European Economic Union in 1973 which directly contributed to the New Zealand dairy export market collapsing, and soon after the price of oil skyrocketed. These all affected the economy negatively and impacted on Māori workers who relied heavily on unskilled and semi-skilled employment. As a result, Māori found themselves unemployed in huge numbers). For example, in 1980 the Southdown Freezing Works closed leading to the redundancy of seven hundred Māori living in Auckland. Two years later the same

happened for the Pātea freezing works with other major closures in Petone and Hawke's Bay (Anderson et al., 2014, p.426).

In 1981 Māori unemployment accounted for nearly a quarter of all unemployment in New Zealand. This deteriorated through the 1980s when the fourth Labour Government's neo-liberal economic policies contributed further to Māori unemployment. 'Māori suffered a job-loss rate of 15.1 percent between 1988 and 1991, compared to the Pākehā rate of 3.1 percent for the same period'. By 1990 the average income for Māori sat at 20 percent lower than New Zealand households as a whole (Anderson et al., 2014, p.426). By 1993, 24 percent of Māori were unemployed, with the unemployment rate among young Māori even higher (Statistics New Zealand, 1996).

It was within this socio-economic environment that Māori pushed for change. They fought for change on the streets of New Zealand and in the corridors of parliament. At the fore was Te Tiriti o Waitangi and a determination to be heard.

Oranga and the Treaty – Protest

The Crown might have viewed the Treaty of Waitangi as central to Māori health in 1840, but the Treaty did not become relevant to Māori health legislation and policy in practice until the 1980s. Two known brief exceptions exist. The first was in 1913 when the Health Department investigated 'potential implications of the Treaty for health policy', but found that nothing in the Treaty translated to free health care to Māori or, at least, those Māori who could afford it (though it was conceded that Ngāi Tahu could be an exception) (Dow, 2006, pp.80-82). On the second occasion, the issue of the Treaty and health (hospitals, specifically) arose again at the conclusion of the First World War, when the Department of Health advised hospital boards via its journal that Māori were not 'entitled to hospital treatment upon different terms to Europeans' (Dow, 2006, p.81). A related article published fifteen months later makes the point clearer and deserves full quotation:

A word might not be out of place in regard to treatment of Māoris. There seems to be a general opinion that any Māori has a right to free treatment. This is entirely fallacious. Māoris are precisely in the same position as Europeans. The Treaty of Waitangi, which is often quoted as implying some obligation on Government to give free medical treatment to the Natives, is absolutely silent on the point, and simply conveys the full right and undisturbed possession of their lands to the Māoris (Dow, 2006, p.81).

Such a shallow reading of the government's Treaty obligations was arguably very generous given the government's failure to fulfil those obligations in the decades prior and to come. Through the 1970s, but particularly in the 1980s, Māori demands for the state to stop alienating Māori land and start fulfilling its Treaty of Waitangi obligations spilled out into the public arena. In 1984, Waitangi Day saw several thousand protesters out on the streets protesting. They represented a 'broad cross-section' of supporters and interest groups: Māori and Pākehā, Tangata Pasifika, church groups, students' groups and others. That year also featured a march to Waitangi from Ngāruawāhia, with the Kīngitanga and Te Kotahitanga coming together in a symbolic reunification of tribal energies harking back to the nineteenth century (Anderson et al., 2014, p.437). The kaupapa was to communicate clearly to the government that it was time to answer for past Treaty breaches.

Waitangi Tribunal—Claims Go Back, Autonomy Goes Forward

In 1985, the government responded to Māori pressure and the Waitangi Tribunal acquired the power to address historical grievances. The first claims reflected longstanding grievances that underpinned the oranga of tribal communities and Māori as a people nationwide. Land and other environment-based claims were heard along with cultural and language loss claims. The Tribunal's report on the te reo Māori claim in 1986 recognised reo Māori as a tāonga (treasure) confirmed by the Treaty of Waitangi and, as such, deserving of the active protection of the Crown. Direct outcomes of the Tribunal's recommendations were that the Māori language was the establishment of Te Taura Whiri i te Reo Māori (the Māori Language Commission) to promote the regeneration of the language, and recognition of te reo as an official language of New Zealand Māori (Anderson et al., 2014, p.453).

Reflecting on other claims, by 1984 the Tribunal had received fourteen, most of which concerned access rights and consultation issues regarding waterways. The Motunui-Waitara case was brought forward by Te Āti Awa claimants and the Tribunal concurred that sewage discharge towards Waitara had polluted the reefs and seafood and added that this infringed on the capacity of hapū to provide manaakitanga (Anderson et al., 2014, pp.420–421). Here the Tribunal demonstrated its effectiveness in that it showed Pākehā the kinds of spiritual relationships Māori had with whenua and moana. Activists drew attention to and demanded remedies for a history of cultural oppression, institutional racism, language loss, and socio-economic inequalities.

The Waitangi Tribunal made a number of important findings on historical claims that had weighed heavy on the shoulders of many iwi. It also, however, developed a set of principles based on the 'essence' of both language versions of the Treaty as a 'foundation for "a developing social contract" between Crown and Māori' (Hill, 2009, p.223). That contract entailed acting as partners, and reasonably and in good faith (Hill, 2009, p.223).

Pushing for Māori Autonomy Within the System

While the Treaty claims process addressed iwi claims related to their tribal wellbeing, Māori also pushed for autonomy within the social welfare and health sectors of government. In 1977, attention was drawn to the paternalism of the Department of Māori Affairs by a State Services Commission report. The department's new secretary, Kara Puketapu of Te Āti Awa descent, responded with the introduction of the policy Tū Tangata ('stand tall'). This philosophy emerged out of consultations with Māori communities and the ideas that Māori leaders developed at annual Hui Whakatauirā. The aim of Tū Tangata was to provide Māori with more say in health care design and delivery, as well as employment and education programmes through Kōkiri (outreach) centres. These centres drew mostly on voluntary Māori workers, with administrative support and direction provided by the Department of Māori Affairs. One of the greatest developments to emerge out of this push for autonomy was the establishment of Kohanga Reo—Māori language pre-schools—in 1982. The 1990s adage of 'By Māori, for Māori, according to Māori values' evolved out of these early developments (Anderson et al., 2014, p.432).

Oranga and the Push for Bi-Cultural Services

Momentum also gathered in the health sector and by the early 1980s Mason Durie notes that ‘pioneering Māori health initiatives had been established’. Whaiora, for example, was a mental health facility within the Tokanui psychiatric hospital. It was based on Māori values and philosophies and also incorporated conventional methods of treatment. Similar initiatives occurred outside hospitals in the community, and tribal authorities also developed a range of health programmes in health promotion, disability support (including mental disability), alcohol and drug management, and primary health care. However, the problem of securing long term and reliable funding was a constant threat to these initiatives. In fact, although the initiatives were tolerated by conventional health services, they were not necessarily endorsed by health authorities or professional bodies (Durie, 2004, p.7).

The Māori Women’s Welfare League added its weight to the call for culturally responsive health services. In 1984, the League published *Rapuora: Health and Māori Women* (Murchie, 1984). The report focused on the health and wellbeing of Māori women and ‘recommended the establishment of whare rapuora, marae health centres, to provide a range of health services’ (Anderson et al., 2014, p.432). According to Harris and Williams, ‘the report and its recommendations offered practical options for a health sector already challenged to be more bicultural’ (Anderson et al., 2014, p.432). It encouraged the use of Māori values and perspectives and greater Māori participation in health services. This groundswell of Māori activity and calls for Māori driven health initiatives ultimately contributed to the Department of Health’s development of a goal to ‘assist Māori people to achieve their highest level of wellbeing’ and to improve their understanding of a Māori worldview of wellbeing (Anderson et al., 2014, p.433).

A Bicultural Health System—Māori and the Department of Health

In 1984 the election of the Lange Labour government introduced neo-liberal policies that included the devolution of Māori welfare to Māori. Devolution was a tricky issue for Māori since on the one hand they were in the unusual position of having secured a degree of genuine government interest in Māori aspirations yet on the other hand Māori were now co-operating to disassemble the machinery of the state which they had come to rely on. Welfare services in particular, were to be in part devolved to Māori at the same time that the government wanted to spend less on them (Anderson et al., 2014, pp.441–442). In addition, the devolution of welfare services to Māori opened the potential for Māori providers to compete among themselves for funding. Fortuitously these challenges had been anticipated by Māori and in 1989 Sir Hepi Te Heuheu organised a large hui at Taupō in order to establish what would soon be called the National Māori Congress. This congress would provide a forum for Māori to pre-empt tensions between various iwi and welfare provider groups. 1990 saw the inception of the congress and its independence from the Crown meant that soon it was regarded as the twentieth century counterpart to Te Kotahitanga (Anderson et al., 2014, p.442).

It was at the Hui Taumata, the Māori Economic Development Conference of 1984, that Māori first formally met to discuss the devolution of services. National had already made small steps towards policies allowing Māori input into service delivery for welfare and economic development. The new Labour government now looked to accelerate

these. Māori then set about authoring directives that looked to building tribal control over initiatives and programmes. According to Kiro (2001, p.5), ‘Māori policy makers and purchasers were innovative in their attempt to shift resources and provision of services to their own communities’. But in so doing ‘weakened government accountability for Māori health outcomes’.

Whakaoranga Report 1984

In March 1984, the Hui Whakaoranga—a Māori health planning workshop—was held at Hoani Waititi Marae in West Auckland. The hui was attended by hospital board members, Health Department officials and other government representatives, staff from private health organisations and voluntary organisations, health workers and community leaders (Department of Health, 1984, p.4). Dr R.J. Baker, the Director of Health at the time, described the Hui as an opportunity for people to learn how Māori defined health, to describe what they saw as their health concerns and aspirations, and to share health solutions that were working for Māori. The Hui was also set in a time in the 1980s when talk of biculturalism had given way to a discourse of multiculturalism, and this infiltrated Dr Baker’s thinking and foreword in the report of the Hui.

The Hui provided an opportunity for those from the Department of Health to talk about the prioritisation of Māori health that year and the next (Department of Health, 1984, p.8). As in previous decades, however, a large portion of the concern for Māori health rested in the development and implement of health education programmes and efforts to increase Māori access to health care through improving ‘cross-cultural understanding between Māori people and health providers’ (Department of Health, 1984, p.8). The influence of the Tū Tangata philosophy was felt in the recognition that the Department of Health needed to work in collaboration with Māori to improve the Department’s understanding of Māori health needs and gain the support of local communities and tribes for initiatives proposed to improve Māori health. The Department of Health was identified as a facilitator and co-ordinator of health care for Māori, with scant mention recorded of officials actively engaging in the Tū Tangata philosophy of Māori self-determination (Department of Health, 1984, p.9).

An understanding that emerged from the Hui was that Māori health was broader than the World Health Organization’s definition of the time, in that that Māori view incorporated the spiritual/wairua: ‘a state of complete spiritual, mental, family and physical unity, harmony and wellbeing’ (Department of Health, 1984, p.15). The foundations for Māori health were described as having their ‘roots in Te Ao Tāwhito—the Old World, where the spiritual, social, cultural and economic circumstances of the Māori was governed by the lore of Tapu’ (p.15). Thus, it was demonstrated at this Hui that Māori had not lost their connection with a deeply held cultural worldview—‘He tāonga tuku iho tuku iho’ (Department of Health, 1984, p.19), that Hui Whakaoranga enabled to be discussed and disseminated more broadly. This view included the long-standing Māori connection with whenua, whānau, and whakapapa and feed into the promulgation of holistic models of hauora, including Te Whare Tapa Whā (Durie, 1998, pp.69-70).

The recommendations arising from Hui Whakaoranga (Department of Health, 1984, pp.23-24) included the recognition of the primacy of Te Taha Wairua and the call for

marae-based community initiatives to support oranga, including the resource allocation to fund these. There were also calls for more Māori to be involved in health, as health practitioners, on hospital boards, and in advisory positions.

Māori Capacity in Health

The 1980s and 1990s saw much change at the higher levels of government. In 1984 the New Zealand Board of Health was established. The following year a Standing Committee on Māori Health was appointed to facilitate engagement between the government and Māori communities. This committee met several times during 1986 and 1987, but was disestablished the next year and exited the scene by authoring its final report urging upon the Minister of Health the importance of further developing a genuinely bicultural health system (Dow, 2006, p.49). During this time and into the 1990s, regional organisations continued to play an important role in Māori health. From 1983 onwards hospitals were operated by 14 area health boards, whereas previously there had been 29 hospital boards. Despite the reduction though, many still found establishing and maintaining consultation with Māori difficult.¹⁴ An example was the Consultative Committee that existed to assist the Hawke's Bay Hospital Board in its transition/amalgamation into an area health board in 1987. The only Māori member of this hospital board was not included during consultation due to their work commitments to the Waitangi Tribunal. A third transition was soon arriving though with the abandonment of the area health boards in 1991, and the establishment of four Regional Health Authorities and 23 Crown Health Enterprises. This was apparently a welcome change since 'few lamented their [area health boards] passing', least of all Māori who found their paternalistic attitude difficult to work with (Dow, 2006, p.54).

By the early 1990s the government was aware and had accepted the existence of significant health disparities affecting Māori. Nonetheless, the higher levels of bureaucracy still lacked a Māori presence. An exception was Moana Herewini who was a Policy Group Co-ordinator for Māori Health, though this position was disestablished in 1992. Another exception was Kim Workman (Ngāti Kahungunu on his father's side) who was appointed as Deputy Director-General (for Māori health) just prior to Te Ara Ahu Whakamua, which he attended. His entry into the health sector came at a time of significant change, and his appointment coincided with the Health Department's transition into becoming the Ministry of Health.¹⁵ This occurred within the context of a 'critical review' by Hekia Parata and Mason Durie who insisted that the Ministry was not in a position to effectively deliver health services to Māori given that of 400 staff, only nine were Māori. (Although small in number these nine formed the Māori Health Group, which was soon to be renamed Te Kete Hauora.) As a result, more Māori staff were taken on, bringing Māori staff numbers up to 30 (Dow, 2006, p.48).¹⁶

¹⁴ This could perhaps be just as correctly put that Māori continued to find difficulty in being consulted with by Area Health boards. Durie noted in 1990 that despite Health Department encouragement, many area health boards 'lacked provision for comprehensive Māori consultation'. Dow, 2006, p.53.

¹⁵ Workman's tenure was somewhat short-lived and was replaced in 1996 by Ria Earp. Dow, 2006, p.49.

¹⁶ A second review of the Ministry of Health was held in 1997 and conducted by the Monitoring and Evaluation Unit of Te Puni Kōkiri. It found that Te Kete Hauora had indeed made significant headway regarding the earlier criticisms of Hekia, Durie and others concerning the Ministry's apparent failure to accord 'Māori health

In 1995 Te Kete Hauora, the Māori Health Directorate at the Ministry of Health, published a discussion document on Māori health, *Ngā Matatini: Strategic directions for Māori health*. This document signalled the government's acceptance that Māori health should be equal to that of non-Māori, in line with its acceptance of the Treaty of Waitangi as 'the founding document of this country' (Ministry of Health, 1995, p.8). The discussion document also built on two major hui held in 1994: Te Ara Ahu Whakamua—the Māori Health Decade Hui, and Hui Whakapūmau—the Māori Development Conference. Participants at Te Ara Ahu Whakamua reinforced the right of Māori to rangatiratanga, and wanted Māori to be able to move to and through the structures of society (e.g., education, health) as Māori. They consequently called for these structures to become culturally responsive to Māori. The major themes emerging from Te Ara Ahu Whakamua were (Te Puni Kōkiri, 1994, p.7):

- Tino rangatiratanga—let Māori determine their own futures
- Strengthen Māori structures—particularly the whānau
- Tackle violence in the family
- Listen to Māori women
- Accept greater personal responsibility for health
- Acknowledge the diversity of Māori
- Focus on outcomes

Health and Socio-economic Inequities

Despite the work undertaken by Māori working at the coalface of government policy, little headway was made overcoming 'the social and economic disparities that challenged Māori lives'. Indeed, Harris and Williams (2014, pp.457, 459) write that during the 1980s and into the 1990s Māori remained overrepresented in many measures including crime, health and housing. Reid (1999, p.93) describes the 1990s as, 'the only decade of the twentieth century in which the health of Māori is, by critical measures, not improving and is likely to be worsening'.

Declines in health occurred alongside the decline in incomes and living conditions. In the case of income, discrepancies between Māori and non-Māori had worsened. By 1996 income for Māori men was at 65 percent of non-Māori. Māori tended to live in smaller and overcrowded houses. Forty percent of Māori school-leavers finished school without qualifications, compared to ten percent of non-Māori (Anderson et al., 2014, p.456). Poor income and living conditions were linked to a range of illnesses, including increased risk of middle-ear infections, especially glue-ear and the loss of hearing that is often associated with that condition (Anderson et al., 2014, p.457). Cancer and smoking related illnesses also featured. By 1993 nearly half of Māori over the age of fifteen smoked regularly, double the rate for non-Māori. Six hundred deaths a year could be attributed to tobacco

a high priority in its corporate policies or practices'. An earlier recommendation by Hekia and Durie was that sixteen Māori policy analysts were needed and that policy analysis be the core function of Te Kete Hauora. By 1997 the Ministry had filled only four of the recommended sixteen policy analyst positions. In addition to the number of Māori policy analysts, TPK also expressed concern as to how the existing analysts were utilised; for the most part only at the start and end of projects. In addition, there was the continuation of a culture of expectation that Māori staff working for the Ministry be responsible for Māori health despite the Ministry's earlier proclamations that 'all groups and section should give priority to Māori health gains'. Similar commitments had been made during the mid-1980s by other government agencies.

use among Māori. Cervical cancer rates were double for Māori women compared to non-Māori women.

Smoking

Prior to the arrival of Pākehā, Māori did not smoke. However, by the late 1700s Māori used tobacco and by the early 1800s it was a common trade item. Men and women either chewed or smoked tobacco, and eventually started growing tobacco plants (Cook, 2013, p.1). Thus, when Maui Pōmare expressed concern about Māori smoking in 1902, Māori men and women had been smoking for more than a century. Early attempts to curb its usage, however, do not appear to have targeted Māori. With the support of the Anti-Nicotine Society, formed in 1883, the first tobacco control legislation in New Zealand was passed in 1903 and outlawed the selling of cigarettes to minors, and of smoking by those aged under 16 years (Thomson & Wilson, 1997, p.11). Prior to this, the word ‘smoking’ only appeared in the Maori Councils Act 1900, which empowered Maori councils to establish bylaws that dealt with such issues as sanitation, drunkenness and smoking (Thomson & Wilson, 1997, p.192). By the 1950s, at least, the government had access to international research which strongly connected smoking to cancer. However, the government’s message was of moderation rather than cessation. In 1953, Dr Turbott, who would soon be the Director - General of Health wrote:

Cut down your smoking, Heavy smokers have more coronary disease than light ones, there is a growing body of opinion that the circulation and lungs may be affected... and there is some connection between excessive smoking and cancer of the lungs. Tobacco has its uses, As a social habit it has become accepted by both sexes the world over. It is used to relieve tension and help relaxation.... What is moderation? The latest American thought is limit yourself to, say, six or eight cigarettes a day.... (Turbott, 1953, p.6).

Again, the message does not appear to have targeted Māori. However, by 1959, Turbott’s first report as the Director- General of Health signalled concern about the rate of lung cancer for Maori women, which was one of the worst in the world (Dow, 2006. p. 69). The growing body of evidence supporting the danger from tobacco did not appear to encourage the government to restrict advertising, promotion or the sale of tobacco. There were also, very few anti-smoking voices in a New Zealand population for whom smoking had become the widespread norm (Thomson & Wilson, 1997, p. 11).

A 1973 study found mortality for Māori women to be seven times that of non-Māori women. The same study found that Māori males were 50 percent more likely to die of lung cancer than non-Māori. In both cases heavy smoking was considered the main cause (Dow, 2006, p.70). The authors of that study cautioned that ethnic disparities would persist unless smoking among Māori was addressed. This was reinforced by a study of the period 1974–8 which found that of the total excess mortality for Māori, 15 percent could be attributed to smoking and 10 percent to alcohol consumption. By this time, the Government acknowledged concerns and ‘kicked into action’. A steering committee comprising people from the Department of Health, Cancer Society and National health foundation was established to consider the World Health Organisation report on smoking and health. They recommended the establishment of an Advisory Committee on Smoking and Health (ACSH), who in turn recommended that the tobacco tax be increased to 25 percent, with the extra income put toward sports sponsorship and health education.

In the 1980s, Eru Pōmare and colleagues produced two significant *Hauora: Māori standards of health* reports (1980 and 1988 respectively) that expressed alarm at the effects of smoking on Māori. In 1998 the Ministry of Māori Development conducted a study of smoking mortality since 1954 and found smoking to account for 31 percent of Māori deaths from 1989–93, nearly double that of the total population. Further studies conducted in the mid-1990s by Māori-led health researchers highlighted the issue of smoking. Nonetheless, Dow describes the response of the government as ‘softly softly’. The Health Department responded by dispensing health education to Māori trade trainees who had migrated to urban centres (Dow, 2006, pp.70–71).

John Broughton of Otago University’s Ngāi Tahu Māori Health Research Unit and co-researcher Mark Lawrence, both advocates of tino rangatiratanga as ‘the only effective way to tackle Māori and smoking’, explained the high incidence of lifestyle diseases among Māori as a function of socio-economic and cultural oppression. Broughton published two volumes on the history of smoking from Cook’s arrival until the 1930s that explored how smoking became incorporated as a cultural norm among Māori (Dow, 2006, pp.71–72). Another explanation offered by psychiatrist Perminder Sachdev was rapid urbanisation and its associated stresses. Sachdev’s explanation is not so dissimilar from Broughton and Lawrence in the sense that included in the stress of urban migration is the cumulative effects of land loss. Echoing this was Papaarangi Reid who in 1993 argued that ‘it was hard for a people to be healthy when they had lost 64 million acres’ (Dow, 2006, p.72).

Poverty

It was also hard to stay alive longer if you were poor. Poverty and income inequalities were viewed as factors in the increased mortality rates for Māori. While non-Māori life expectancy continued to improve into the 1990s, improvements in Māori life expectancy stalled (Reid, 1999, p.92). Blakely and colleagues (2005, p.2233) looked back at this time and found that,

Māori deaths were underestimated by a quarter... during the 1980s and early 1990s... The gap in life expectancy increased from an average of 7.7 years in 1980–84 to 10.8 years in 1996–99 for Māori... in comparison to [non-Māori, non-Pacific]. Deaths among 45–64 and 65 plus year olds, and cardiovascular disease and cancer deaths, were the main contributors to these disparities.

Again, connecting the death of Māori babies to the socio-economic environment into which they were born, Pōmare and de Boer (1988, p.80) describe the death rate of babies aged one to eleven months as a key indicator of the social and economic environment of these babies’ families. The disparity between Māori and non-Māori continued throughout the 1970s and into the 1990s, with Māori babies between 2.1 and 2.5 times as likely to die post-neonatally than non-Māori babies. In 1987–1990, 70 percent of Māori infant deaths occurred in this age group, with the leading cause of death being sudden infant death syndrome (SIDS). Reid (1999) notes that the previously decreasing death rate began to increase from 1991 onwards (whereas the death-rate continued to decrease for non-Māori babies).

Poverty or low incomes and poor housing were linked to poor Māori health outcomes and high inequities relative to Pākehā. However, meta-causes beyond the economic were

also targeted. In 1988, Pōmare and de Boer wrote that the ‘social, economic and cultural issues associated with [urbanisation] are immense and are at the root of the unequal health experience of the Māori people in New Zealand society today’ (Pōmare & de Boer, 1988, p.31).

Return Migration and Rural Māori Inequities

As Māori health headed toward crisis point, many of the Māori migrants of the mid-twentieth century were returning home to their papakāinga. They had spent decades working, raising whānau and shaping urban Māori communities. In West Auckland alone, there were more than fifty organisations supporting the foundations of oranga. These included branches of the Māori Women’s Welfare League, Māori Wardens associations, branches of Te Kōhanga Reo, and Tū Tangata schemes, all focused on growing strong tamariki and rangatahi under the guidance of kaumatua and kuia (Anderson et al., 2014, p.434). Ageing Māori migrants had played a massive role in creating culturally familiar spaces for their tamariki and mokopuna. But ultimately they had no chance of overcoming the overwhelming socio-economic and cultural challenges that were hitting them from all directions. It was often within their old Māori Affairs homes or state rentals that their children and mokopuna were squeezed, dependent on welfare benefits. From the 1970s, organised gang culture permeated Māori lives, as did imprisonment, the institutionalisation of babies, and the abuse of drugs and alcohol.

For some elderly, the strong desire to return home came with anxiety about leaving behind struggling children and mokopuna. Some stayed put because of it. It should also be noted that return migration also included younger Māori wanting to connect with tribal homeplaces they had never known. The rise of Treaty politics and a growing iwi presence in te ao Māori had ignited among some a determination to learn about and contribute to home communities. Others looked to home communities in desperation, as a means of escaping the poverty of urban life (Williams, 2015, pp.219-220).

But going home was not easy. The idea that urbanisation was at the ‘root of the unequal health experience’ was not necessarily so. Going back home provided much cultural nourishment, but access to health services was often more difficult in rural areas. Many of the elderly returned home with chronic illnesses (diabetes, arthritis, respiratory problems). Even younger people returning were more likely to suffer from some form of illness, physical or mental. In the Hokianga, doctors visited local clinics only twice a week. Any emergency care or ailment that required a doctor outside of those clinic days meant travelling long distances to the nearest hospital an hour away. Many elderly were unable to return for this sole reason (Williams, 2015, pp.225-29).

Additionally, the poverty many experienced in the cities also existed in rural communities. It was difficult to access adequate housing. Returning whānau often improvised, living in caravans, patched-up old homesteads or garages. Williams writes that ‘the government’s introduction of the Papakāinga Housing Scheme in 1986 provided a degree of support, but the issue of multiple land ownership and an inability to find employment to service mortgages meant that most people could not access a home through the programme’. She continues that ‘by 1988, researchers described a “Māori

rural housing crisis due to decades of neglect by housing authorities coupled with a return of Māori families to tūrangawaewae” (Williams, 2015, pp.233-34).

Government welfare policies, which prevented work-able Māori from collecting unemployment benefits in remote rural communities, also provided an obstacle for people wanting to return to their whenua. Thus, the lack of employment (one of the main reasons contributing to urban migration decades earlier) continued to plague local Māori economies (Williams, 2015, p.237). The relevance of the lack of employment to the retiring elderly is that many of them needed whānau support when they returned home, or soon after. This was the case with Matutina, whose mokopuna was sent back home to live with her in the early 1980s. Almost every home had a mokopuna. And for good reason. Knowledge was customarily passed down from kaumatua and kuia to mokopuna, and mokopuna provided their grandparents with warm company and aroha (Metge, 1995, pp.182-190). The reciprocity of whānau life was still strong.

Oranga and Tamariki

By the later decades of the twentieth century, however, it was necessary to explicitly articulate to the government how important the foundations of oranga were to the care of Māori children. As noted in chapter five, the adoption acts of the mid twentieth century had already eroded the centrality of whakapapa and whānau, but in the 1980s this issue came to the fore again.

As background, in 1985 an advisory committee was established to inquire into the presence of racism in the Department of Social Welfare. Chaired by John Rangihau, the advisory committee released its report —*Puao-Te-Ata-Tu*—in 1988. It pointed to institutional racism at the core of the Department of Social Welfare and a complete lack of understanding of Māori values and practices related to the centrality of whakapapa, whenua and whānau in Māori lives. In the preface it stated: ‘At the heart of the issue is a profound misunderstanding or ignorance of the place of the child in Māori society and its relationship with whānau, hapū, iwi structures’ (p. 7). The elimination of both cultural racism and deprivation formed the report’s first two recommendations, with others speaking to the need for more appropriate and culturally responsive welfare support for Māori, including the nation-wide implementation of the Maatua Whāngai programme (foster parenting) that had been piloted in 1983.

While *Puao-Te-Ata-Tu* influenced the Children, Young Persons, and their Families (CYPF) Act of 1989, by placing whānau, hapū and iwi as the primary groups responsible for the care and protection of Māori children, the Act was also a cost-cutting measure that looked to reduce the economic cost of maintaining children in care. Between 1991 and 1993 expenditure on care and protection fell by more than 20 percent and while Māori children were being placed with kin, a disproportionate burden of cost cuts was shouldered by Māori because of a disparity in payments for kin vs. non-kin placements (Duncan & Worrall, 2000, p.290). The Office of the Commissioner for Children was also established under the 1989 CYPF Act as an independent monitor of child welfare. Māori participants at a 1990 national conference called by the Office of the Commissioner for Children ‘recommended the appointment of a Māori Commissioner for Children to work in equal partnership with the present Commissioner and to share resources to ensure that

whānau, hapū, and iwi are empowered to assume responsibility for their own children' (Ministry of Health, 1996, p.8). This recommendation was not implemented.

Assessing Oranga in the Late Twentieth Century: Whakapapa, Whenua and Whānau

Oranga was always about more than health, as defined in western terms. The loss of whenua (tribal home places, tūrangawaewae) had dominated Māori concerns throughout the nineteenth and twentieth century; it was the solid anchor upon which whānau and whakapapa could thrive. Looking at the challenges that Māori were facing in both urban and rural areas brings into focus how oranga was still vulnerable by the 1990s in both urban and rural areas. The nature of the challenges were slightly different, but common to them was the government's failure to acknowledge the value and invest resources in the oranga of Māori whānau. The settlement of Treaty claims led some to suggest that iwi now had to take more responsibility for the wellbeing of their communities. Many iwi did (and still do) invest in the oranga of their hapū communities, but they never had the resources necessary nor the bulk of responsibility to address the health inequities that had built up for almost 200 years.

Reflecting back to the New Zealand wars, the massive waves of whenua alienation, institutional racism, assimilationist policies and practices, the denigration and marginalisation of Māori culture and values, it could be said that times had changed, but they also had not changed. The sheer weight of that difficult past, layer upon layer, merely added to the weight of ongoing racism, inequalities, poverty and apparent blindness of the government to the basic cultural, economic and social needs of Māori people in the late twentieth century.

Whakamā and the need to forget was inherited. By the twentieth century it entailed the shame of still not getting it together, of being told that it is time to forget the past and move forward, or the feeling that one still did not really belong anywhere. For many, it seems the way forward was to forget; forget by abusing drugs or alcohol, forget by abusing one's whānau. Another way to forget was by killing yourself. A way to forget was to shout out karakia.

He Aha te Mate? What is Wrong? Mental Health and Disability

Inequities in Mental Health

The Board of Health's 1971 *Review of Māori Health* suggested that the incidence of mental health for Māori and Pākehā were equivalent, but that statistics for Māori mental health were unreliable. By 1977 reliability improved when the Department of Statistics released its Inaugural *Social Trends in New Zealand*. Mental health inequities were very clear. For accuracy the results as reported by Dow will be quoted verbatim:

The standardised rate of Māori first admissions had increased from 122/100,000 in 1963 to 169.4 in 1974. A second table, based on age-specific rates highlighted the altered ratios for Māori and non-Māori, with the former rising from 120.9 in 1963 to 190.2 in 1974 while the latter had decreased during the same period from 174.7 to 156.6 (Dow, 2006, p.179).

Mental health inequities worsened at an alarming rate. The 1980 *Hauora Report* stated that 1974 admission rates for schizophrenia and associated conditions was 1.6 times higher for Māori than non-Māori. In 1984, the *Rapuora* study by the Māori Women's Welfare League (Murchie, 1984) found that 1 in 5 Māori women in their sample suffered stress symptoms, 1 in 20 reported chronic depression, and 1 in 25 were heavy drinkers (noted in Baxter, 2008, p.33). Papers compiled and presented by Durie and Dr Max Abbott of the Mental Health Foundation to its 1985 conference showed that the situation had worsened with Māori making up 13.5% of all psychiatric admissions at a time when Māori were only 7.3 percent of the population. In less than *two* decades, Māori admissions to psychiatric institutions had doubled (Abbott & Durie, 1987, pp.58-71).

He aha te mate? Searching for Causes

In 1985, Mason Durie spoke at a Mental Health Foundation conference and attributed the rise in mental illness among Māori to the long-term deterioration of the cultural institutes of whenua, whānau and reo, not urbanisation as some suggested. He also described how mental health workers were ill-prepared to deal with the worsening situation (Durie, 1985, pp.1-6). Jennifer Rankin, a psychiatric registrar at Tokanui Hospital, also spoke and attributed the increase in Māori mental health admissions to the 'deliberate and systematic erosion of the classical Māori value systems', the effects of which would be felt by urbanised Māori young especially. As such, a holistic approach to mental health was needed. Wi Keelan of Porirua Hospital advocated the incorporation of traditional Māori values in order to transform the field into a bicultural institution (Dow, 2006, p.180).

In 1991 Dr Erihana Ryan, by then the only Māori practising full time as a psychiatrist, argued that the disproportionate rates of mental illness among Māori was 'fundamentally an expression of colonization' (Dow, 2006, p.183). Her statement was made to a Commission of Inquiry that arose from the Health Department's concern regarding the 'disproportionate number of Māori psychiatric patients'. The report, which investigated the processes of admission, discharge and release of 'certain classes' of psychiatric patients, detailed the various failings of the health system as well as challenges for the future (Dow, 2006, p.183). Likewise, a 1993 Ministerial Inquiry into mental health services noted that,

Māori now make up a significant proportion of consumers of Mental Health services, they are more likely to be admitted involuntarily, have poor outcomes after first admission and their readmission rates increased by 40 percent over the last decade. It also noted the possibility that a high acceptance of abnormal behaviour leaves illness undetected and untreated... [and, it continued] ...there are insufficient culturally appropriate community services to prevent admission; current services are not designed to meet the needs of Māori people; and the social and economic environment is hostile to Māori people' (Ministerial Enquiry Report, 1993, Durie, p.37).

Failings and Challenges: Māori Mental Health Services

Prior to the 1980s, institutional care was dominated by Pākehā culture and Pākehā people. In the early 1980s, however, Māori took a more active role in the mental health sector. Durie writes,

The evolution of active Māori participation in mental health services... coincided not only with the transfer of mental health services from institutional care to community centres, but also with increasing recognition of the significance of culture to mental health, the indigenous rights movement, positive Māori development and Māori over-representation in mental health services (Durie, 2004, p.6).

Many of the challenges Māori faced in their attempts to exercise autonomy in the transformation of the mental health sector was that the system was too culturally and administratively rigid to accommodate Māori worldviews and practices. Participants in *Tuia Te Ao Marama*, an oral history project with Māori mental health nurses who practised 1950–1990, stressed the importance of *taha wairua*, *mātauranga Māori*, *te reo me ōna tikanga*, and understanding how to position *mate Māori* in relation to Western mental health system/models (Baker & Sewell, 2016, p.41). Māori nurses felt they had to ‘leave their Māoriness at the door’ because customary practices such as *karakia* were viewed as unacceptable within the workplace (Baker & Sewell, 2016, p.39).

Māori providers of mental health services likewise described feeling ‘choked’ by their inability to have Kaupapa Māori service proposals accepted, while at the same time being inundated with reporting requirements. As a result, they were held to contracts and had to deliver services that fitted with general or mainstream criteria endorsed by Regional Health Authorities (RHAs). Many therefore felt they were compromising what they could deliver to Māori patients and their whānau, but the alternative was no service at all (Inquiry Under Section 47 Of The Health And Disability Services Act 1993 In Respect Of Certain Mental Health Services Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley May 1996 (pp.137–40).

The most alarming aspect of this failure to provide culturally responsive mental health services to Māori is that it existed, and was known to exist for so long. Baxter (2008, p.3) writes that individuals, organisations and agencies expressed concerns about Māori mental health throughout the 1980s and 1990s. In 1994 a report on the health status of New Zealand by the Public Health Commission listed ten threats to Māori health. Topping this was mental health, as well as alcohol and drug use. This, the report stated, would not improve until Māori communities were better resourced. Te Puni Kōkiri soon weighed in on the matter when it released its report on Māori mental health trends between 1984 and 1993. The report described Māori as ‘a culture under siege’. Similar sentiments appeared in Pōmare’s third *Hauora Report* of 1995, which called for a ‘comprehensive review of Māori mental health’ because in the years covered by this volume (1971–1991) the rate of Māori admissions to psychiatric hospitals was increasing, while the non-Māori rate was falling, and Māori were accessing mental health services later in their illness than non-Māori (Pōmare et al., 1995, p.116).¹⁷ In 1997 Durie presented to the Māori Mental Health Summit at Wellington. Much of the content of the Mental Health Commission’s 1998 *Blueprint for Mental Health Services in New Zealand* came from this and included a push for dedicated kaupapa Māori services coupled with ‘outcome measures relevant to Māori culture’ (Dow, 2006, p.186).

According to Dow, as late as 1998 detailed data on ethnic differences were still lacking (Dow, 2006, p.184). How much ‘detailed data’ was required to move swiftly on Māori

¹⁷ The disparities between Māori and non-Māori continued into the 2000s and the publication in 2002 of *Te Puawaiatanga Māori Mental Health National Strategic Framework*. This Framework also acknowledged that Māori contexts were important in treatment (Baxter, 2008, p. 3).

mental health is unknown. Nevertheless, in 1998 the Māori Health Commission's first report listed mental health and 'Māori participation in the health sector' as its central priorities. The commission's report praised the adoption by the Māori Unit at Tokanui Hospital of an eight-point 'special needs' programme that incorporated the Treaty of Waitangi, its use of cultural assessment and the involvement of whānau, tohunga, karakia, rongoā and tangata Māori staffing the unit (Dow, 2006, p.185). Moves toward kaupapa Māori mental health services were being made, but excruciatingly slowly. According to Dow, by the 1990s 'mental health problems were now recognised as the number one health concern for Māori' (Dow, 2006, p.187). Specific goals outlined in the Ministry of Health's 2002 *Te Puawaitanga: Māori Mental Health National Strategic Framework* included increased access to tohunga and rongoā, as well as a 50 percent increase in the number of Māori working in the field. One provider though, Hauora Waikato, expressed their concern in 2000 that fewer Māori were entering the field (Dow, 2006, p.187).

Given the history in this report, it is difficult to assess these latest moves in the mental health sector without some cynicism. In 2015, the suicide rate for Māori males was 25.3 per 100,000; 1.7 times that of non-Māori. For Māori females, the suicide rate was 2.4 times that of non-Māori females (Ministry of Health, 2015b). Lives depended and continue to depend on the government providing Māori with the resources and power to get services right for Māori.

Different Sectors—Same Challenges: Disability

Just as important as saving Māori lives, is ensuring that Māori experience a good quality of life in the first place. However, a recent report into Māori disability provides sombre reading. Keri Ratima and Mihi Ratima, write,

Disability support services have not only been unresponsive to Māori—they have been destructive. Services consistently dismissed Māori cultural preferences. Some of the most striking examples relate to the impact of institutionalisation on Māori with intellectual disabilities and their whānau (Ratima & Ratima, 2007, p.189).

The destruction they refer to is something that this report has raised over and over again. The destruction is the denial of a person's right to exist, engage and thrive in their culture. To belong and to give belonging. When the whānau of Matutina placed their kuia in Carnavron Hospital, it was a consequence of a destructive system of colonization. One that generated policies that decreased the capacity of a whānau to care for a vulnerable kuia in her time of need. A whānau without the financial means to leave the workplaces of a city in which their kuia had settled them two generations earlier. A system that never acknowledged nor appreciated the centrality of whakapapa, whenua and whānau to iwi Māori. Placing their kuia in a hospital was a consequence of a social welfare system that prioritised budget over people, and governments extending back to the nineteenth century that told Māori that their whenua was a commodity not a tupuna. This story sits in this final part of the report as an example of the ease by which disability and mental health are a whānau that Māori know too well.

While both Māori and non-Māori have disabilities, the impact on Māori is more severe as the responsibilities of caring and accessing support for those with disability rests with whānau who often have limited resources (Ratima & Ratima, 2007, p.189). Ministry of

Health (2015c) statistics also point out that the rate of disability among Māori is higher than the rate among Pākehā, including disability among children and young people. Prior to the 1980s, Māori with disabilities were removed from their homes and whānau. Within those institutions they were often renamed and any fluency in te reo they may have had was lost (Ratima & Ratima, 2007, p.192). Deinstitutionalisation in the 1980s may have promised more participation in society for people with disabilities, but it was poorly planned and resourced with little thought given to reconnecting Māori back to their people and rohe (Ratima & Ratima, 2007, pp.192-93).

In 1992/3 funding and responsibility for many disability support services transferred from social welfare to the four Regional Health Authorities (Ministry of Health, 2003, p.4). While this seemed like an opportunity for Māori organisations to contract to deliver disability support services in their communities, our Kahui Pakeke were very cynical about how the funder/provider split of the early 1990s pushed Māori-led services away from the marae and into independent Māori provider organisations (Hui Pakeke, Napier, 2019). Ratima and Ratima (2007, pp.194–195) do, however, describe the cultural responsiveness of Te Roopu Taurima o Manukau, a service supporting Māori with intellectual disabilities and their whānau. Even so, these authors conclude their chapter by saying that there remains, in 2007, ‘huge potential to make positive change in the Māori disability sector’ (Ratima & Ratima, 2007, p.196).

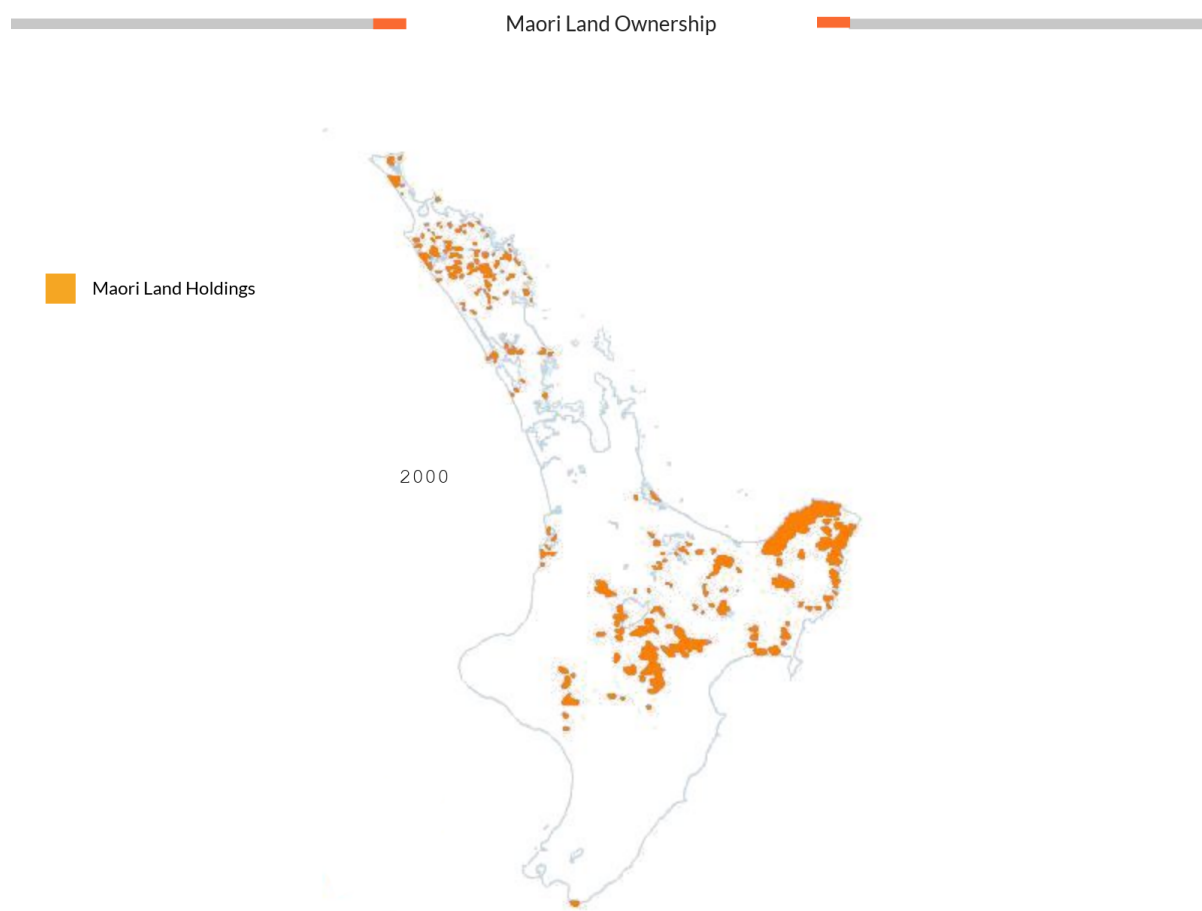
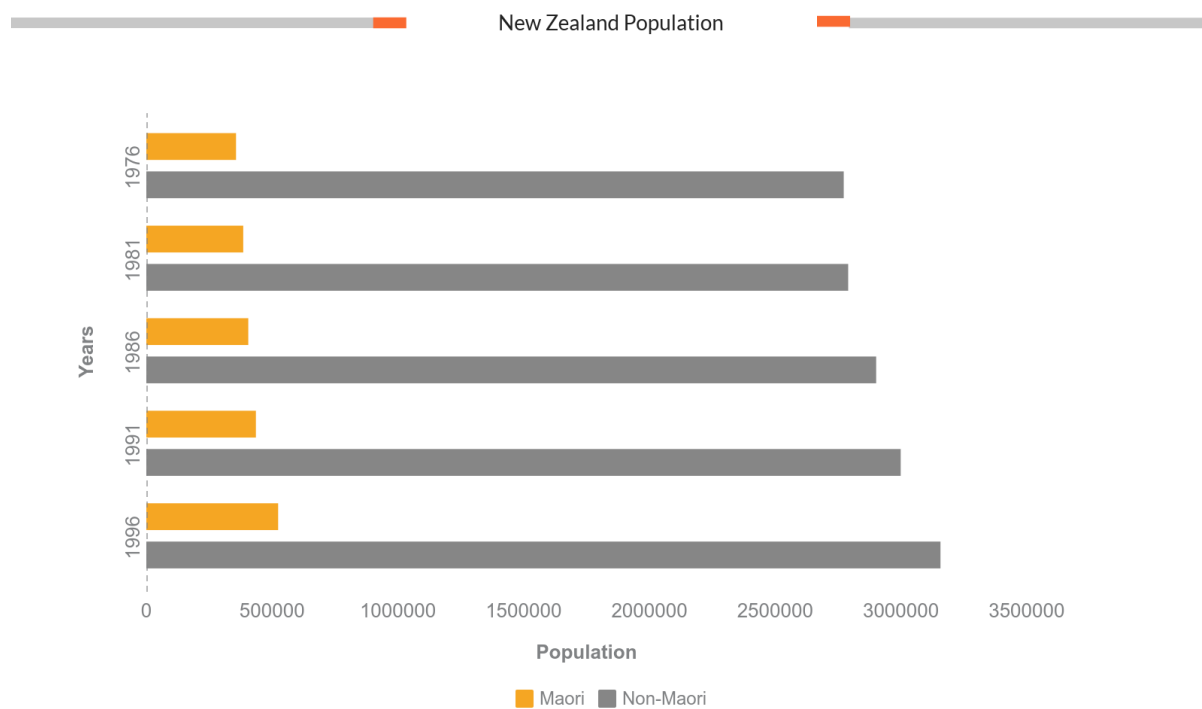
In 2001, disabilities and impairments were distinguished and the New Zealand Disabilities Strategy that year stated that, ‘Disability is the process which happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have’ (Minister for Disability Issues, 2001, p.3). Prior to this sea-change, notions of disability reflected an emphasis on physical and mental health, and valued independence (Ratima & Ratima, 2007, p.189). These were incompatible with Māori holistic views of health and the valuing of interdependence, to the extent that Māori with disabilities value security of identity as a central part of their wellbeing (Ratima & Ratima, 2007, p.190). This, combined with issues related to the collection of quality data on Māori and disability (e.g., definitions of disability and ethnicity, methodology), mean that the planning and provision of disability support have consistently been challenging. In spite of these limitations, current disability data may be used as a reflection of Māori disability in at least the 1980s and 1990s. If this assumption is correct, then one in five Māori lived with a disability during these decades (or age standardised: 24.0% of Māori vs. 16.7% of non-Māori). Ratima and Ratima (2007, p.191) note that,

With the exception of learning impairment, Māori adults are over-represented in each major impairment category. The most common types of impairment experienced by Māori adults are mobility, hearing, and agility impairments. Māori also experience more severe impairment than non-Māori.

Conclusion

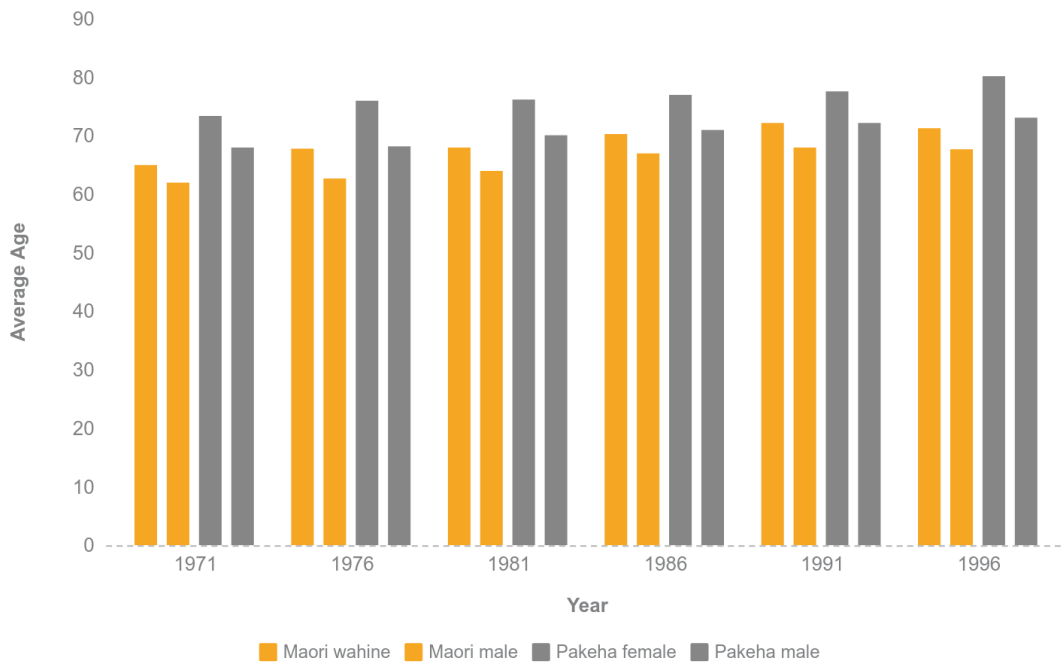
From birth to old age, Māori were consistently over-represented in negative health statistics during this period, from disability to mental health, and from chronic diseases to infectious diseases. It is no coincidence that Māori were also consistently over-represented in negative socio-economic statistics during this period. The two are linked. Poverty and poor living conditions contributed to Māori health inequities. So too did institutional

racism, and the government's failure to act swiftly and both fund and support autonomous Māori health providers. Yet, health inequities are just one aspect of the much bigger picture of Māori wellbeing – oranga. During this period, it is clear that oranga was unattainable for many Māori. The impacts were harsh and, from a Māori perspective, bordering on cruel. Access to the whenua was still blocked by laws, policies and financial regulations, one's whakapapa could be wiped out by CYFS child placement officers, and whānau heaved under the pressure of the outcomes of health inequity and their placement at the bottom of a socio-economic ladder. This chapter raises, again, the intergenerational transference of whakamā, extending back to the late nineteenth century when the massive trauma of land loss and cultural destruction took place. The report argues that not much had changed. The descendants of that loss continued to carry and live out that trauma in the late twentieth century, all the while becoming another layer of trauma for the next generation to inherit. During this period Māori continued to struggle with the consequences of health inequities. Moreover, oranga was not attainable for many. Without oranga Māori were (and still are) unable to live good and culturally fulfilling lives.



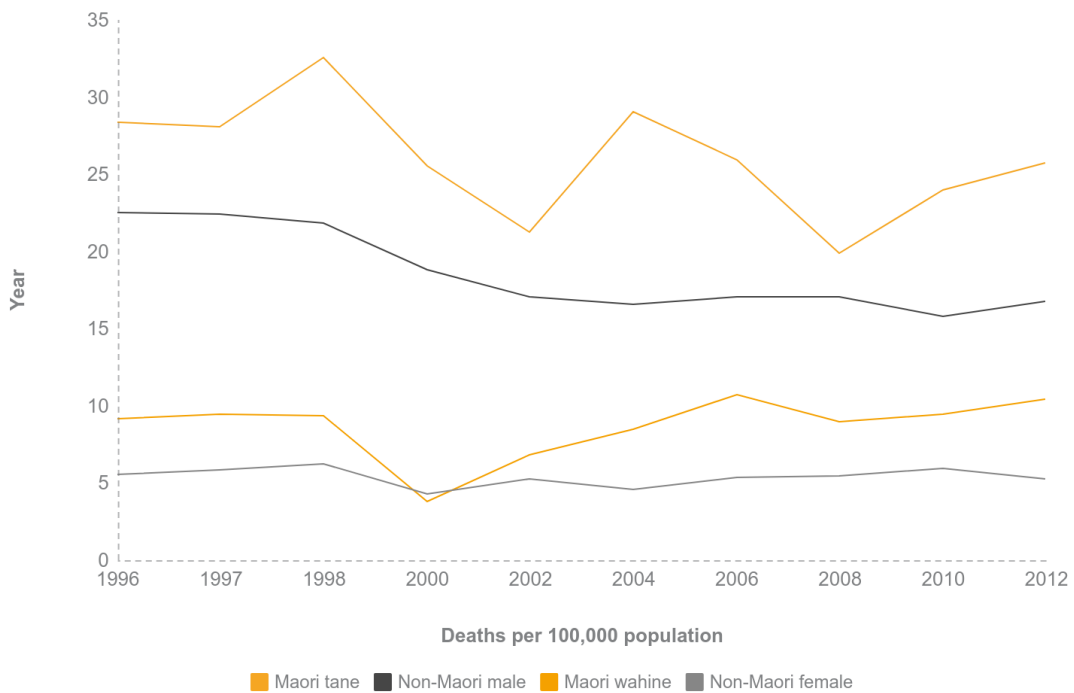
• Source: 'Maori land loss, 1860-2000', URL: <https://nzhistory.govt.nz/media/interactive/maori-land-1860-2000>, (Ministry for Culture and Heritage), updated 17-May-2017

Life Expectancy

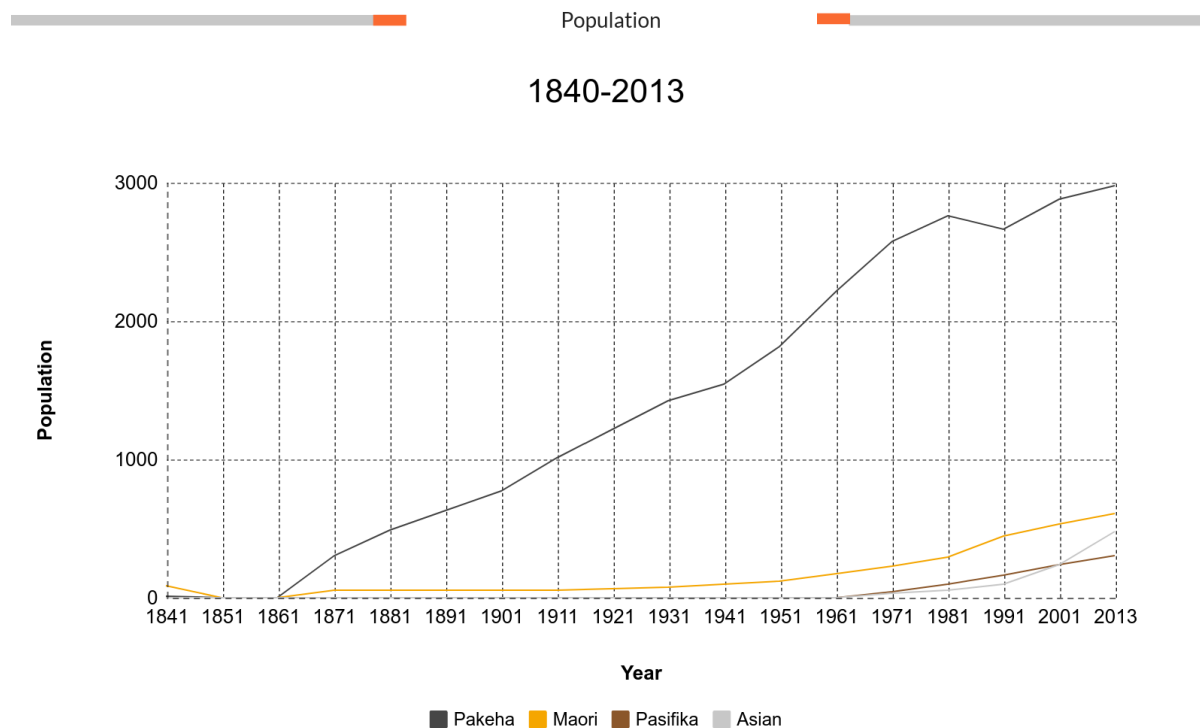


Suicide Rate

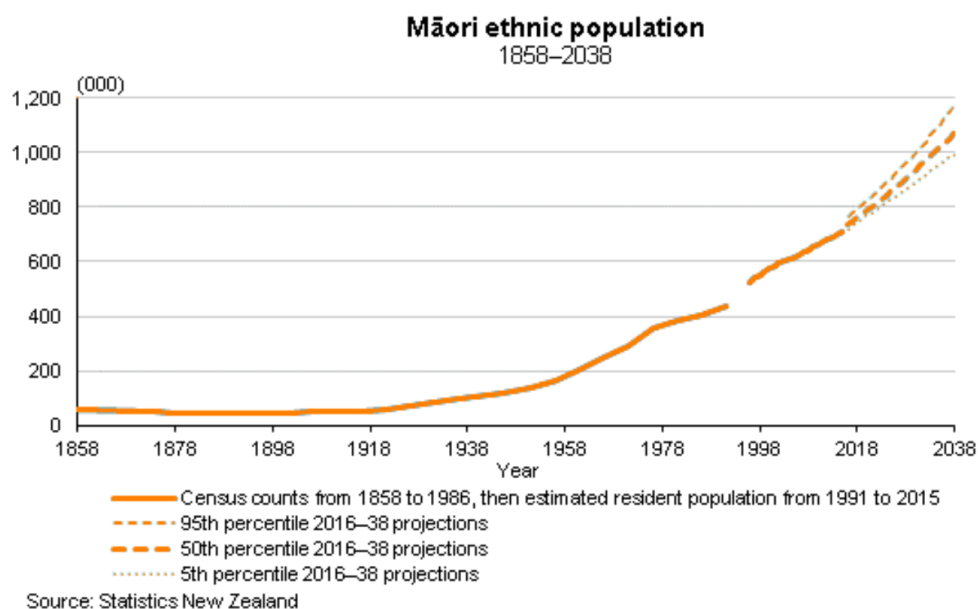
1998-2012



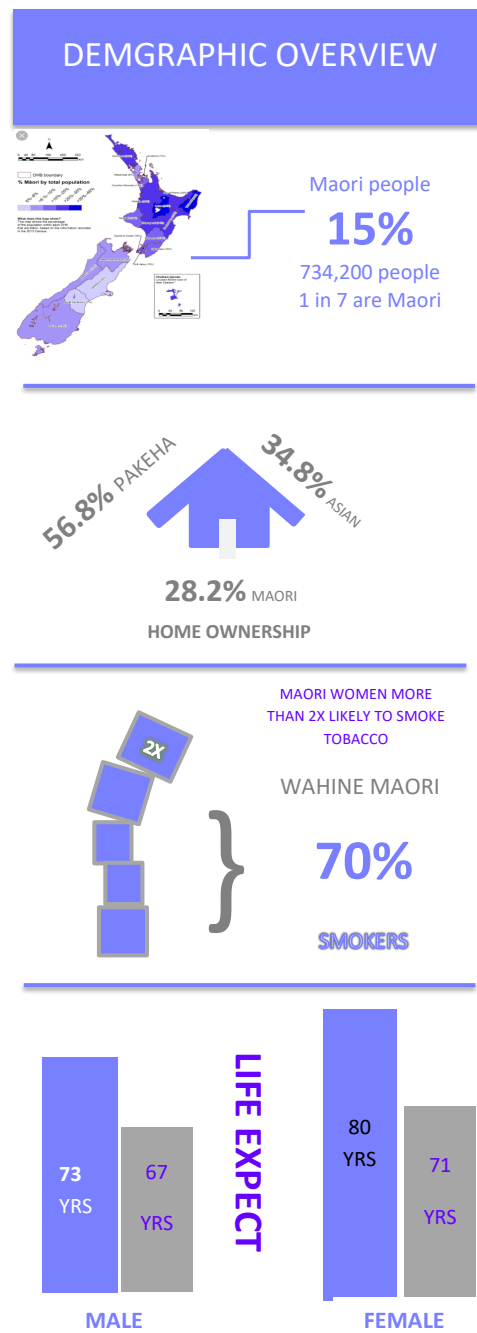
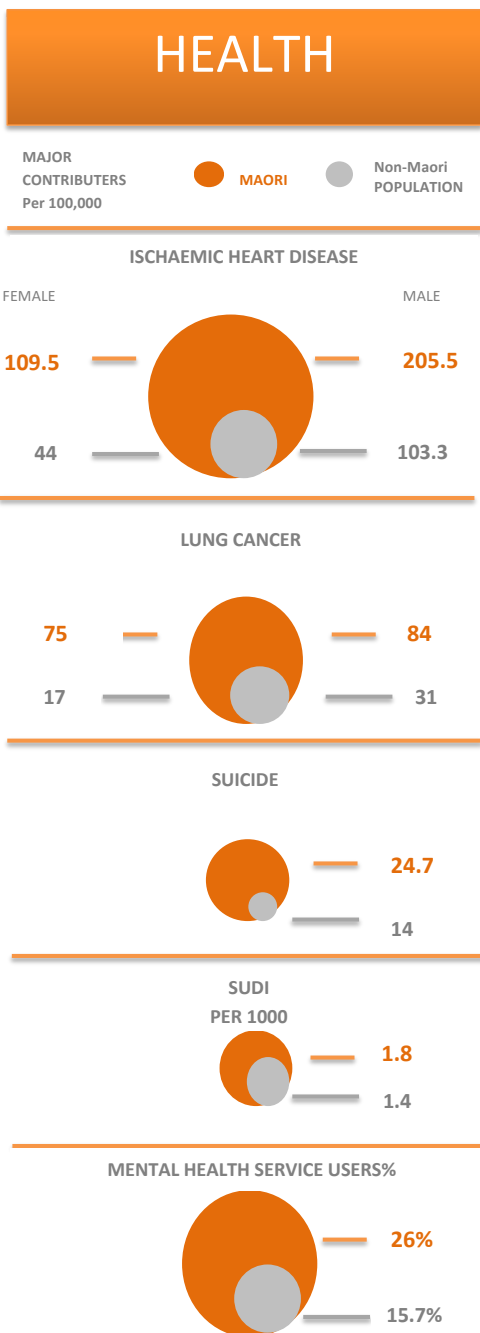
• Source: Stats NZ. Retrieved 16 August 2019 from: http://archive.stats.govt.nz/browse_for_stats/snapshots-of-nz/nz-social-indicators/Home/Health/suicide.aspx



• Source: Ian Pool and Natalie Jackson, 'Population change - Key population trends', Te Ara - the Encyclopedia of New Zealand, <http://www.TeAra.govt.nz/en/graph/28720/new-zealand-population-by-ethnicity-1840-2013> (accessed 16 August 2019)



• Source: http://archive.stats.govt.nz/browse_for_stats/people_and_communities/maori/maori-population-article-2015.aspx



Reference: Stats NZ, 2013, 2015

2. Ministry of Health. 2015. Maori health/Tatau-kahukura Maori health stats

Chapter 7. Conclusion

We began this report with Māori journeying to Aōtearoa and the description of the three principles or determinants of oranga that enabled them to thrive in their new home; namely, whakapapa, whenua and whānau. From this arrival in the late thirteenth century until the second half of the eighteenth century the Māori population steadily increased. By the time of their first encounters with the first Europeans in 1769 the average life expectancy of Māori was on a par with the peoples of Europe. Over the span of Māori contact with colonisers, Māori have maintained a commitment to oranga and to living culturally enriched lives. However, a wide system of assimilation driven by government policies and practices has steadily, and at times aggressively, undermined Māori capacity to maintain oranga. Similarly, policies and practices have driven a wide system of assimilation that has included the health system and contributed to Māori-Pākehā disparities in not only health but in the determinants of health (e.g., education, income, housing). The narrative of oranga is one of rangatiratanga; the narrative of disparities is about the undermining of rangatiratanga.

What began as mutual exchange between Māori and Pākehā very quickly turned to an uneasy relationship and then conflict. The trauma of war and land loss was exacerbated by disease and loss, which then set the context for cycles of disease and loss as the Māori population declined throughout the nineteenth century. Those who survived were left hungry and homeless. The alienation of the whenua continued into the twentieth century, as did arguments about who and how Māori health care should be funded. The result has been, at best, ad hoc health care delivery to Māori and consistent levels of Māori health inequities.

The report argued that when oranga was placed under extreme pressures, such as in the late 1800s and late twentieth century, Māori experienced and expressed trauma as whakamā, a feeling of powerlessness and shame. Whakamā is not posited as a purely psychological state of mind, although it most likely does impact on mental health. Whakamā is introduced as a cultural response to trauma, which could manifest as a determination to discard cultural customs, te reo, or anything that marginalised oneself. As mentioned in chapter six, it could also possibly manifest in even worse self-destructive ways.

By the end of the twentieth century, the dual narratives of oranga and health inequities had converged to a place so deep in negativity that Māori had not only lost a full sense of wellbeing as a people, but they had done so as second-class citizens within New Zealand's health system. Whichever way you looked at it, Māori had become doubly disadvantaged, stuck between a severely dismantled and marginalised worldview of oranga and a health system that failed to meet their basic needs. The wellbeing of Māori had hit rock bottom; by the 1970s and '80s Māori were feeling the impact of an economic downturn and the introduction of free market policies. Māori wages were decreasing and Māori unemployment levels increasing.

Then the autonomy over oranga that Māori fought so hard to exercise for nearly 200 years was abruptly devolved by the government to them (with conditions) within a very short timeframe—basically around two decades in the late twentieth century. Change was overdue and urgent. The foundations of oranga had become so damaged that its holistic intricacies were having to be remembered, recited and reframed, not only to educate the state and non-Māori, but to inform a generation of Māori whose cultural identity, stability and wellbeing had become tenuous. Māori at the coalface of government policy development were in a severely disadvantaged position on many levels. Not only did they have to address the huge health inequities that had accumulated over one hundred years, but they also had to reimagine a view of oranga that could be translated and incorporated into a ‘bicultural’ health system that had never had a place for the centrality of whakapapa, whenua and whānau.

‘Puao-Te-Ata-Tu became official policy in 1987, but the recent attempt to deprioritise the placement of Māori children with their iwi under the Vulnerable Children’s Act confirms persisting cultural tensions between Māori and state ideas about what ‘care’ really means to Māori’ (M. Williams, 2019, p.66). Even worse, the current fight to stop the uplifting of Māori new born babies into state care shows how little progress has been made over the last thirty years. ‘Not one more baby’ is a cry that points directly back to the ‘not one more acre’ cry that Māori chanted as they marched to save their whenua in 1975. Whakapapa, whenua and whānau – oranga is at more risk today than it was then. Māori need to be at the centre of the solution to reviving the wellbeing of their own people.

In his introduction to the Hui Whakapūmau, Tā Mason Durie described the hui as ‘an opportunity to foster discussion and debate on the position of Māori’ (Māori Studies Department, 1994, p.3). He put Māori development within a wider historical context, especially the legislative context and the social, economic and cultural policies developed between 1985 to 1994 that impacted upon Māori. The other speakers at the hui likewise rose to the challenge of looking backwards in order to move forward, and their words are useful in understanding this phase of Māori health history.

The crisis of infectious disease among Māori largely obscured other aspects of health and oranga during the earlier decades of the twentieth century. As the decades progressed though, we have seen the emergence of health inequities among Māori which now feature disabilities and mental health. The desire to attain oranga and health equity drove much of the Māori political activity that has been described in this report. After more than a century of dormancy we have seen the re-emergence of the Treaty of Waitangi, both as a focal point for Māori protest and a means by which the right of Māori to exercise their rangatiratanga might see the light of day.

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