

Committee on the Elimination of All Forms of Racial Discrimination Shadow Report: Aotearoa New Zealand



Runanga Whakapiki Ake i te Hauora o Aotearoa
Health Promotion Forum of New Zealand



Tāmaki
Treaty
Workers



29 June 2017

Unuhia te rito o te harakeke, kei hea te kōmako e kō? Ui mai ki ahau, 'He aha te mea nui o te Ao?' Māku e kī atu, 'He tangata, he tangata, he tangata.'

If you remove the central shoot of the flaxbush, where will the bellbird find rest? If you were to ask me, 'What is the most important thing in the world?'

I would reply, 'It is people, it is people, it is people.'

This whakataukī (a Māori proverb) by Meri Ngāroto, of the Te Aupōuri people of New Zealand, speaks directly to the importance of people. It is people who lie at the heart of institutional racism; either as targets, perpetrators or bystanders. It is people who, through this Shadow Report, wish to highlight the existence of institutional racism in Aotearoa. It is people who are challenging its presence and its normalisation within our lands.

This report will no doubt provoke as much anger and anguish as it will enthusiasm: anger at the unfairness of it all, anguish at the scope and breadth of its existence, and yet enthusiasm and hope in the fact that there are many who are committed to address these violations. In a very real sense this Report reveals institutional racism as a set of modifiable realities and calls for integrity between what is and what should be.

To encapsulate the essence of this report we must first acknowledge the shared history of racism, guilt, misunderstandings and failings. It is from this space of acknowledgement that we can move forward. As our history binds us, so too does our futures and this report provides us with an opportunity to transform the language of racism from separatism and division to one-ness.

For Māori everyone and everything is related and connected. This Māori world view can be found in all understandings of life both physical and meta-physical. Therefore, it is fair to say Māori and non-Māori are connected through this kaupapa and that non-Māori too carry the burden of this un-justness and injustice. They too are affected by tuku atu, and tuku mai the concept of balance and reciprocity. Although the weight of privilege is not equal to the burden of oppression, when one commits an injustice against another, they commits it against themselves, they commits it against humanity and therefore we are all poorer for it.

Our tamariki, mokopuna and the coming generations depend on us to pave a way forward. They entrust us with their futures and this report provides clear recommendations to enable the simple security of equality. The principle of 'He waka eke noa' – we are all in this together – is not only for those in power positions or government, it is for all of us who choose to dwell on this land.

The truths that are woven throughout this report are unshakeable; it is not up to Māori alone to deconstruct and redress the injustices of institutional racism; so let us learn from the past so as to not entomb the future. We are all in this together.

Nā te aroha, te pono, te tika
Ka ora ai te tangata

We welcome the opportunity to submit to the United Nations Committee on the Elimination of Racial Discrimination (CERD). We are concerned about institutional racism enacted in Aotearoa by the New Zealand (NZ) government, its Ministers and their officials against the indigenous Māori population.

We are a substantial collective of non-governmental civil society organisations including: STIR: Stop Institutional Racism, Te Rūnanga o Aotearoa, New Zealand Nurses Organisation, Auckland University of Technology, Pukenga Consultancy Ltd, Tāmaki Tiriti Workers, Health Promotion Forum, Awa Associates, Waka Oranga and the New Zealand Public Health Association. Collectively we represent thousands of health professionals and concerned New Zealanders.

Our collective is interested in the right to health. For Māori, hauora and oranga (health) are inclusive terms for the physical, spiritual and cultural wellbeing of Māori as individuals and collectively. It is widely accepted that there are long-standing significant disparities in health outcomes for Māori - shorter lives, less access to primary health care, less access to treatment, and misdiagnosis and mistreatment. Along with many health professionals, we do not accept that such inequalities are acceptable, just, necessary, or fair in a developed country like Aotearoa New Zealand.

Human rights are interdependent, indivisible and interrelated. Māori have equal and inclusive right to the highest standards of health. The right to health is articulated in the constitution of the World Health Organization (1948) and under article 25 of the *Universal Declaration of Human Rights* (UN, 1948). The particular State is responsible for ensuring this right is achieved under article 5 e (iv) of the *International Convention on the Elimination of All Forms of Racial Discrimination* (UN, 1966); under article 12 of the *International Convention on Economic, Social and Cultural Rights* (UN, 1976); under articles 11 (1)(f), 12 and 14 (2)(b) of the *Convention on the Elimination of All Forms of Discrimination against Women* (UN, 1979); under article 24 *Convention on the Rights of the Child* (UN, 1990); under article 24.2 of the *Declaration on the Rights of Indigenous peoples* (UN, 2007); and under article 25 *Convention on the Rights of Persons with Disabilities* (UN, 2008).

In this report, we wish to raise our interest in and concerns arising from:

1. Constitutional transformation.
2. Call for a national action plan to end racism.
3. Te *Tiriti o Waitangi* in the health sector.
4. Institutional racism in health policy.
5. Disestablishment of te Kete Hauora.
6. Māori wards in local government.
7. Institutional racism in public health contracting.
8. Revoking of DHB Māori health plans.
9. Suitably funded, Māori-led health solutions.
10. Māori health workforce.
11. Pay equity for Māori nurses.
12. Māori representation in the media.
13. Whānau hauaa (Māori with disability).
14. Māori and cancer.
15. Intergenerational trauma and patterns of harm.
16. Māori and seclusion in mental health.
17. Racism in violence in whānau.
18. Ihumatao.
19. Waitara Lands Bill and Pekapeka Block.
20. Trans Pacific Partnership Agreement.

Taking the health sector as its main focus this report will demonstrate the nature and extent of institutional racism within the Aotearoa. While the above mentioned nineteen points reach beyond the public health sector, the representatives of our collective are experienced researchers and community practitioners within this specific sector. However, since racial disparities are extremely evident within the health sector, we understand that the findings can be transferred to other social sectors.

Representatives of our collectives will be attending the CERD forum in Geneva in August 2017.

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1. Constitutional transformation

...indigenous rights and the role of the indigenous voice in international forums are areas where New Zealand should be leading the world. The special place [of Māori]... in our systems of governance is a foundation for our national identity and cohesion (Waitangi Tribunal, 2011, p. 690).

The Waitangi Tribunal (2014) - a permanent independent commission of enquiry - has ruled that Māori did not cede sovereignty to the British in signing *te Tiriti o Waitangi* in 1840. The NZ constitutional arrangements, which are currently the subject of a 'constitutional conversation', are based on the false assumption of British (settler) sovereignty.

In his report on NZ, the UN Special Rapporteur, (Stavenhagen, 2006) found that the inherent traditional governance bodies of Māori were not constitutionally recognised. He recommended that *te Tiriti* be entrenched constitutionally, and that *iwi* and *hapū* be considered as likely units of Māori self-determination. Likewise, CERD (2013) in their concluding observations recommended the NZ government ensure the status of the *Treaty of Waitangi* be discussed in the context of constitutional reform.

The Constitutional Advisory Panel (2013) is charged with leading the constitutional conversation. Their scope of practice is restricted and problematic because it positions *te Tiriti* and Māori as subordinates to the current Westminster parliamentary system, and denies inherent Māori *tino rangatiratanga*. The Māori Iwi Leaders Forum on constitutional transformation instigated a Māori-led constitutional conversation, which has begun to articulate a *Tiriti*-based constitution (Matike Mai Aotearoa, 2016) with a target of implementation by 2040 (the 200th anniversary of the signing of *te Tiriti*).

Recommendations:

- That the government respond to the call from the Māori Iwi Leaders Forum by enacting and resourcing the recommendations of the Aotearoa Matike Mai report by 2021.

2. Call for a national action plan to end racism

Despite the government's endorsement of human rights treaties and *te Tiriti o Waitangi*, racism has become a normalised part of NZ society. International and New Zealand research demonstrates the detrimental impact of discrimination and racism on physical and mental health (Paradies et al., 2015). The outcomes of racism are manifest in the significant and enduring disparities in health, economic and social well-being between Māori and non-Māori (Marriott & Sim, 2014; Robson & Harris, 2007).

A study by Houkamau, Stronge, and Sibley (2017) analysed data from a self-report questionnaire completed by 1790 Māori sampled as part of the NZ Attitudes and Values Study. Houkamau et al. (2017) used a Bayesian regression model to assess the links between perceived discrimination and fifteen social, economic and psychological indicators of well-being including respondents' healthcare access, evaluation of respondents' health, job security, self-esteem, life satisfaction and psychological distress. They found that 43% of the sample reported experience of at least some form of discrimination. Roughly a third agreed that they are discriminated against for their ethnicity. Nearly 1 in 10 reported high levels of discrimination. This is significantly higher than previous estimates (Ministry of Social Development, 2016); which may reflect rising rates of ethnic discrimination. Higher levels of perceived discrimination among Māori were associated with poorer outcomes in every measure, across multiple domains.

NZ has a generic national human rights plan and a range of ad hoc strategies and interventions that attempt to deal with inequities between population groups. *CERD 1(2) maintains state parties should pursue the end of racism through all appropriate means and without delay.* Although recommended by the World Conference against Racism, the Durban Review Conference, CERD in their concluding observations and the Human Rights Council (United Nations, 2014), NZ continues to lack a coherent national strategy to document and eliminate racism.

A national plan to appropriately document and eliminate racism would provide a focus for government and civil society action, enable progress towards the ending of racism to be monitored, and could make a contribution to honouring Treaty obligations. To this end, Came and McCreanor (2015) have developed four evidence-based pathways that could structure to a possible NZ national strategy. It is crucial to establish a mechanism for the documentation of racial and ethnic discrimination, including appropriate data on representation of indigenous and

ethnic groups within state institutions. To eliminate racism, Came and McCreanor suggest the following pathways i) address historical racism, ii) improve racial climate, iii) pursue equity by enacting systems change interventions in public institutions, and iv) mobilise civil society for collective impact. It is also crucial to establish mechanism for the documentation of racial and ethnic discrimination, including appropriate data on representation of indigenous and ethnic groups within state institutions.

Recommendations:

- That the Human Rights Commission undertake a national-conversation about how racism manifests and how all forms of racism may be interrupted constructively when they occur.
- That the NZ government develop and invests in the implementation and evaluation of a whole-of-government national action plan to eliminate racism by 31 December 2018.

3. Te Tiriti o Waitangi in the health sector

Te Tiriti o Waitangi (1840) is the founding treaty of the colonial state of New Zealand. It was negotiated between the British Crown and Māori rangatira (chiefs) at a time of peace and Māori dominance. Te Tiriti reaffirms Māori sovereignty, guaranteed Māori the same rights and privileges as British subjects and the protection of Māori taonga (treasures) such as health (Durie, 1998).

Over the last 177 years, the settler government has consistently pursued policies and practices which have breached te Tiriti. These breaches have often been consistent with definitions of institutional racism: a pattern of behaviour with differential treatment that disadvantaged Māori while advantaging others. Such racism has taken the form of inappropriate action or inaction in the face of the health needs and aspirations of Māori.

Approximately 100 health-related deeds of claim (WAI2575) connected to Crown Ministers and/or Crown Officials' breaches of te Tiriti are currently before the Waitangi Tribunal (Isaac, 2016). Many of these claims relate to government inaction in face of systemic health inequities between Māori and non-Māori (Marriott & Sim, 2014; Robson & Harris, 2007).

The Crown needs to redress past breaches and ensure no further breaches of te Tiriti occur within the health sector. This will best be enabled through strengthening: health policy, human resource practices, and sector-wide quality assurance systems.

Recommendations:

- That *te Tiriti o Waitangi* be embedded within all health policies to inform prioritisation and investment decisions.
- That human resources strategies be strengthened to ensure new Crown officials and existing staff have or are supported to develop the necessary cultural and political competencies to work with te Tiriti and in partnership with Māori.
- That quality assurance systems be re-orientated to ensure meaningful engagement with te Tiriti at all levels of the health sector by December 2018, and engagement that includes measurable outcomes for service delivery.

4. Institutional racism in health policy

The process of colonisation saw the supplanting of customary Māori public health systems (Durie, 1998) with a predominately mono-cultural colonial health system (Dow, 1995). It included the outlawing of Māori practices and the marginalisation of Māori knowledge. Health policy is of strategic importance in that it determines where resources are invested and can enable or prevent health inequities. Racism in health policy compromises the right to health.

From a range of sources, including testimony from a group of Māori health leaders with over 180 years' collective experience in the sector, Came (2014) identified five modifiable sites of institutional racism within public health policy making. These sites are: i) majoritarian decision-making practices that marginalise Māori views; ii) the failure

to draw on Māori evidence and over-reliance on best practice evidence from the global north (with limited or no indigenous analysis); iii) deficiencies in cultural and political competencies of policy analysts; iv) flawed consultation processes and, v) organisational sign-off processes that dilute Māori content.

Collectively these findings indicate the systemic failure of quality assurance systems (Ministry of Health, 2003), existing anti-racism initiatives, and health sector leadership to detect and eliminate racism.

Recommendations:

- That structural mechanisms be implemented to ensure Māori input into: i) setting health policy agendas; ii) making health investment decisions; and iii) representation on senior management teams.
- That State Services Commission establish mandatory review processes that ensure Māori evidence and cultural frameworks be cited and explicitly used to inform all health policy.
- That consultation processes and advisory group processes be strengthened to enable meaningful Māori participation and partnership particularly in areas of high health inequity.

5. Disestablishment of te Kete Hauora

For decades Māori have been overrepresented in negative health statistics (Ministry of Health, 2015b). The Ministry of Health (the Ministry) has pursued the advancement of health equity and more specifically Māori health through the leadership and policy advice from te Kete Hauora (TKH) (the Māori policy unit) within the Ministry. TKH has been an important structural mechanism for Māori participation in health policy and decision-making, providing Māori health expertise and cultural input. Beyond their policy role they have also engaged in monitoring achievement of Māori health outcomes (Manchester, 2006). In March 2016 te Kete Hauora was disestablished (Ministry of Health, 2015a).

Under the new Ministry structure there is a solitary Chief Advisor Māori Health, who has denied racism within the NZ health sector (Brown, 2016). The Chief Advisor does not have a budget, or any resources to implement or support Māori initiatives. This has created structural barriers to active engagement with Māori and obstacles to the creation of measurable and achievable goals to address inequities.

In the enduring absence of health equity, Came and Tudor (2017) argue the health sector needs special structural mechanisms and remedies, such as a dedicated Māori policy team to address the complex challenges of health inequities. More investment and appropriate infrastructure in Māori health is needed, particularly within the Ministry.

Recommendation:

- That the Ministry of Health re-establish a dedicated and adequately resourced Māori health policy and research team by July 2018 with the authority to make decisions.

6. Māori wards in local government

Under the *Local Government Act 2002* councils must seek meaningful engagement with Māori. These instructions are in place to help ensure that te Tiriti o Waitangi is honoured by local government. There are specific obligations on councils that are intended to facilitate participation by Māori in local authorities' decision-making processes. The *Act* charges local authorities with a clear responsibility to take an informed approach to understanding Māori community values, issues and aspirations, just as they need to understand those of other communities. Any territorial authority may resolve that the district be divided into one or more Māori wards. The *Act* outlines the process a council or community needs to go through, i.e., a council resolution and public notification.

Under existing legislation, councils can choose to establish Māori wards, however, if 5 percent of voters sign a petition opposed to such a move, the decision then goes to a binding referendum, whereas ALL other general wards are decided on by the council alone. This effectively means that a small proportion of the community can, and do, block Māori representation.

There is inconsistency across the country with councils using reference groups, memorandums of understanding, liaison committees, kaumātua (elder) forums, while some have no mechanism for Maori engagement and

participation at all. This is not equitable. The legislation is broken and legally allows for a breach of (indigenous) rights within a system that does not follow the same (legal) process for all involved. It is a divisive and racist piece of legislation by existence.

Recommendations:

- That the NZ government amend the current legislation to establish mandatory Māori wards and Māori constituencies across all local authorities throughout Aotearoa by December 2018.
- That the NZ government take the time to have kanohi ki te kanohi (face to face) conversations with iwi, and more importantly hapū, about the kind of relationship they would like to see established and developed with their local authority.

7. Institutional racism in health contracting

Public institutions within NZ have long been accused of mono-culturalism and institutional racism (Came, 2012; Jackson, 1988; Ministerial Advisory Committee, 1988; Walker, 1990). In NZ, generic providers (public health units, primary health organisations, and non-governmental organisations) and Māori health providers are contracted by the government to deliver public health services. The rhetoric of the NZ government procurement policy (Controller and Auditor-General, 2008) and health policy (Ministry of Health, 2016b) establishes a funding environment where all providers are theoretically treated equitably. This however is not the case.

A nation-wide survey of public health providers by Came, Doole, McKenna, and McCreanor (2017) have identified a pattern of inconsistencies in Crown (government) treatment of providers consistent with definitions of institutional racism. Quantitative data showed Māori providers were found to have: i) shorter contract timeframes; ii) higher perceived compliance costs; iii) more intense monitoring; and were iv) audited more frequently. Qualitative data showed more intense and difficult interactions between many Māori providers and their funders.

Recommendations:

- That senior managers within the public sector have key performance indicators in their employment contracts to ensure they take responsibility to identify, prevent and remove institutional racism within their domains.
- That, across the health sector, the Quality Health and Safety Commission ensure quality assurance systems are strengthened to detect, prevent and minimise institutional racism, and, specifically, that funders:
 - Develop transparent criteria for the allocation of discretionary and/or one-off public health funding and publish it on-line and consistently follow it;
 - Make the application of prioritisation guidelines mandatory for investment and disinvestment decisions and ensure Crown Officials have access to the relevant training to apply these guidelines; and
 - Ensure a consistent approach to the allocation of costs of living and/or Forecast Funding Track across health providers.

8. Revoking DHB Māori health plans

District health boards (DHBs) are regional government health providers with responsibilities around planning, funding and delivering health services. DHBs have particular legislative responsibility to reduce health inequalities and improve Māori health. Māori health plans have been widely used within the health sector as a mechanism for prioritising and monitoring Māori health outcomes. Through these plans, organisations can declare their intentions, commitments and progress towards improving Māori health against defined measures and indicators and be publicly accountable through reporting processes.

In November 2016 the requirement for DHBs to develop and report on Māori health plans was revoked and obligations to consult were downscaled (Ministry of Health, 2016a). This is a retrograde step in relation to the pursuit of health equity and Māori health (Came & Tudor, 2017). These plans and reports were a pathway for Māori input into health planning. Likewise, information from these plans was used to populate Trendly^{beta} (<http://www.trendly.co.nz/Home/Performance>) an innovative web-based resource developed by George Grey that enabled Māori and others to monitor and bench-mark DHB performance in relation to Māori health.

Recommendations:

- That mandatory Māori health plans be reinstated as mandatory by December 2017, and include penalties for non-performance or non-compliance.
- That requirements for DHBs to consult with Māori as Treaty partners be strengthened.
- That senior management teams at DHB have key performance indicators in their employment contracts in relation to Māori health which are monitored, and that these contracts include consequences for non-performance.
- That all mainstream health providers develop, implement and report on Māori health plans by December 2017, and that the contracts with these providers including penalties for non-performance or non-compliance.

9. Suitably funded, Māori-led health initiatives

Holistic Māori health models as exemplified for example in the work of (Durie, 1998, 1999) have been drawn upon and adopted into the policies of many government-led initiatives. While the acknowledgement and use of these models is a positive step toward Māori-driven solutions, the extent of the disproportionate burden of illness suffered by Māori health is not reflected in the funding allocated to Māori-led initiatives (Came, 2012).

Outcome measures in most health interventions do not align with Māori worldviews and values, particularly measures pertaining to nutrition, physical activity, and other 'physical' health interventions. For instance, the core focus of government-focused healthy lifestyle programmes is, frequently, weight loss and progress in clinical blood markers such as glycated haemoglobin (HbA1c) or cholesterol, rather than Māori-centred measures. While Māori may benefit from reductions in weight and improvements in blood markers, the outcome measures and assessment tools that are used reflect government priorities rather than Māori values – a perspective that suggests that those values, or, at least, those that don't align with the dominant discourse, are not a priority.

While culturally-driven initiatives will resonate better with Māori (Ratima, Durie, & Hond, 2015), the support of such initiatives is a step toward realigning health services to improve health outcomes. Dr Ihirangi Heke (n.d.) recently developed the *Atua Matua Māori* health framework which, next to other emerging approaches based on mātauranga (Māori knowledge), highlights a Māori-led approach to health. That is a shift from clinical outcomes, to health initiatives driven by and assessed according to whakapapa (genealogy and links to people and land) and mātauranga Māori. The cultural relevance of health initiatives targeting Māori would be enhanced if the outcome measures used reflected Māori values and views on health.

Recommendations:

- That the Ministry and other health funders fund Māori-led health interventions at a rate which better matches the disproportionate burden of illness experienced by Māori.
- That the Ministry and other health funders fund interventions that use outcome measures based on the values of Māori and more specifically the iwi (tribe) in the region they serve.

10. Māori health workforce

Employment for Māori is important for whānau to achieve their aspirations, and is a critical determinant of health. In 2016, (Statistics New Zealand) some 57.5% of Māori in the working-age population were employed (i.e. paid to work one or more hours per week) (Statistics New Zealand, 2016). The health sector is a major employer of workers and Māori are high-users of the health system. The Human Rights Commission (2011) indicated that in health another form of structural discrimination is the under representation of Māori in the health workforce.

Russell, Smiler and Stacey (2013) make a compelling argument that matching the demographics of the workforce to the demographics of the population, improves health outcomes and access to services for Māori. Curtis, Wikaire, Stokes, and Reid (2012) concur that a matched workforce can enable access to culturally appropriate health services for all health consumers and is a critical step in addressing health inequities.

Currently, Māori form 15% of the population (Statistics New Zealand, 2016b) and Māori nurses make up only 7% of the nursing workforce (Nursing Council of New Zealand, 2015). Health Workforce New Zealand (Ministry of Health,

2017) have predicted that, in order to match the nursing workforce to the ageing population, will, by 2028, require an additional 10,209 Māori nurses. There are currently issues around the recruitment of Māori students into nursing programmes, retention of students within and the successful completion of such programmes (Foxall, 2013). Māori new graduates are also consistently reporting difficulties in securing professional roles. More senior Māori staff report issues around progression, promotion and accessing workforce development opportunities.

The Ministry of Health (2008) have identified a number of upstream and downstream determinants of Māori participation in the health workforce. These include healthy work environments, affordability of tertiary education, and institutional racism. Research (Navigate, 2002) commissioned by the Ministry around the retention of Māori staff within their own organisation identified staff felt culturally compromised at work, and they recommended actions be taken to normalise being “Māori” within the Ministry (Navigate, 2002).

Recommendations:

- That an overarching Māori health workforce strategy be developed for regulated and unregulated workforce utilising a systems approach, looking at the determinants of Māori participation in the health workforce, including institutional racism.
- That the Ministry of Health establish a single repository for Māori health workforce data to enable monitoring.

11. Pay equity for Māori Nurses

Māori whānau often have complex health needs and experience considerable socio-economic disadvantage. Successful relationships and outcomes require tailored interventions from health practitioners skilled in western medicine and te Ao Māori. Māori nurses are critical to successful Māori outcomes for whānau (families), hapū (sub tribe) and iwi (tribe) and are named as key stakeholders in much contemporary health policy (Ministry of Health, 2016b).

Significant pay disparities, of up to approximately 25% (Human Rights Commission, 2011) exist for kaimahi (workers) who work in Māori and iwi providers when contrasted with other parts of the health sector. These pay disparities are acknowledged by the Minister of Health (Coleman, 2016) and occur even in cases where staff have the same qualifications, and occur despite the International Labour Organisation *169 article 20, section 2* which states that ‘Governments shall do everything possible to prevent any discrimination between workers and (b) equal remuneration for work of equal value’.

Pay disparities seem to be the unintended consequence of how the government currently funds healthcare, which fails to address the differences in infrastructure investment required for Māori versus other larger health providers. (Also see section 7). Contracts awarded to Māori providers do not allow for pay equity nor recognition of the dual competencies of many Māori nurses.

For some years, through correspondence with the Ministry of Health, through select committees, and successive Ministers of Health, Te Rūnanga and the NZNO have lobbied for structural discrimination, as manifested in pay disparities to be urgently addressed. They have also previously raised this issue at the United Nations. There is still no movement on the longstanding pay parity campaign *Te Rau Kōkiri*. Each year this issue remains unresolved. Māori whānau continue to receive less income than the families of nurses working within DHBs and other parts of the health sector.

Entrenched pay inequities are now affecting the retention and recruitment of nurses into Māori health. Māori nurses are vital for the future health and wellbeing of whānau, hapū and iwi and, given demographic prediction, the NZ population as a whole. Action is required to develop a Māori nursing workforce strategy with further investment, resourcing and vision to achieve this goal.

Recommendations:

- That urgent action and leadership be taken by the Minister of Health and/or the Ministry of Health to reconfigure contracting and funding processes to ensure pay parity for nurses working in Māori and iwi health providers and elsewhere in the health sector,
- That the NZ government develop, fund and resource a comprehensive Māori nursing workforce development strategy by December 2018.

12. Māori representation in the media

The UN Special Rapporteur (Stavenhagen, 2006) identified the existence of systematic negative descriptions of Māori in New Zealand media. Biased portrayals are created both by the choice of negative events as 'news' and by the depictions of the actors in those events. Research published since 2006 confirms that New Zealand media are still representing Māori people negatively. News items in which Māori, especially Māori men, harmed children provided the majority of items involving Māori broadcast in English-language news programmes despite a range of other stories being available (Nairn et al., 2012). Studies have shown that Māori perspectives on events are unlikely to be provided by authorised speakers from concerned hapū and iwi (Rankine, Moewaka Barnes, McCreanor, Borell, & Gregory, 2014).

Other researchers have shown that, while statements by Māori speakers are often 'balanced' by comments of non-Māori speakers, the reverse is rarely true (Barclay & Liu, 2003; Hodgetts, Masters, & Robertson, 2004). Several studies have identified how pressures on Māori to assimilate into 'a common culture' appear in news, commentary, and sports reporting (McCreanor, Rankin, & Moewaka Barnes, 2010; Phelan, 2009; Phelan & Shearer, 2009).

This steady flow of negativity affects non-Māori New Zealanders causing them to fear and resent Māori (Gregory et al., 2011; Moewaka Barnes et al., 2012). This is particularly problematic for Māori who have to live with anger, criticism, and sniping from workmates, acquaintances, and opinion leaders that erodes their health and wellbeing (Moewaka Barnes, Taiapa, Borell, & McCreanor, 2013).

Recommendations:

- That the NZ government critically monitor its own corporate and policy communication to minimise anti-Māori themes.
- That the NZ government invest in anti-racism interventions challenging societal racism in television, radio, print and social media.

13. Whānau Hauaa

Approximately 1 in 3 Māori in New Zealand are whānau hauaa (or Māori with disability). Whānau hauaa are disproportionately represented in negative health and social outcomes (Ministry of Health, 2015b). The average income of whānau hauaa is less than \$16,000 annually compared with \$25,000 for all New Zealanders (Statistics New Zealand, 2014). Data is not readily available in relation to health and social outcomes particularly in relation to whānau hauaa. This lack of data compromises the responsiveness of policy and the purchasing of health services.

Accessible housing options remain a significant issue for whānau hauaa. Due to the lack of modified state houses and affordable and accessible rental properties some whānau hauaa are placed in rest homes intended to serve old people.

Emerging research by Huhana Hickey (Under review) shows there are significant barriers to whānau hauaa accessing basic health care and disability services. These barriers include institutional racism, lack of connection and engagement, transport, treatment and prescription costs, lack of cultural expertise, physical structure of buildings, childcare issues, and lack of access to tri-lingual (Māori, English, sign) interpreters.

Despite being a signatory to the *International Convention on the Rights of Persons with Disabilities* (UN, 2008) and the *Declaration on the Rights of Indigenous Peoples* (UN, 2007), the New Zealand government has not substantially addressed any part of the convention as it relates to indigenous peoples with disabilities. In the recent supreme court case *Atkinson vs Ministry of Health* (2012), the government has significantly excluded whānau members from within the household being paid as carers (with a handful of exceptions). Culturally it is important for Māori to practice manaakitanga (support and care) and care for their own whenever possible through whanaungatanga (active family relationships).

Recommendations:

- That the NZ government ensure consistent whānau hauaa representation in decision-making roles and forums internationally and in relation to domestic disability sector planning, policy making, service delivery and evaluation.
- That the NZ government commission a regular disability census every five years with over recruitment of whānau hauaa to enable the identification of health needs and aspirations to inform policy work in this domain.
- That NZ government policy be changed to enable Māori to be paid carers for their whānau members.
- That the NZ government develop an implementation plan to fulfil their obligations in relation to *UNCRPD* and *UNDRIP* by 31 December 2018.

14. Māori and cancer

Cancer is a significant public health issue in New Zealand. Of particular concern is the sustained, disproportionate and unjust burden of this disease on Māori (Robson, Purdie, & Cormack, 2006). The NZ health system is more likely to fail Māori across multiple points and levels of the cancer continuum and the foundation of bio-western ideologies has manifested sustained privilege for non-Māori adults for decades (Cormack, Robson, Purdie, Ratima, & Brown, 2005; Hill et al., 2010).

Cancer survival has multiple complex drivers, the most important of which are level of co-morbidity and stage of diagnosis however the stark and ongoing ethnic inequities are indicative of health system privileges and health system failures (Signal, 2016). Total cancer incidence is around 20% higher in Māori compared with non-Māori New Zealanders while mortality is almost twice as high (Robson, Purdie, & Cormack, 2006).

The manifestations of structural disadvantage are not necessarily limited to any one step in the cancer journey but, rather, are small, incremental and accumulating (Hill, Safarti, Robson, & Blakely, 2013). Differential access to primary care, screening and quality treatment for Māori can be seen within different regions and over most cancer types. This indicates institutional racism exists within the NZ health care system (Signal, 2016).

The prevalence of institutional racism can also be seen in cancer risk-reducing strategies. Māori communities are saturated with modifiable ill-health determinants including socio-economic disadvantage, overcrowding, lower education levels, mental health challenges and commercially driven carcinogens such as tobacco, alcohol and unhealthy food. There is increasing excess incidence and mortality in several obesity related cancers (Teng et al., 2016) so the emerging role of commercial determinants and their operation within the trade and political economy need critical analysis (Kickbusch, Allen, & Franz, 2016).

Māori do not live within bio-western paradigms so the ongoing colonial narrative that dominates the cancer continuum requires urgent realignment. The impact of racism in cancer doesn't just insult Māori bodies, it assaults mana, wairua, mauri and whakapapa (Goza, 2017). The decolonisation of the cancer continuum is a rights based assertion that demands equality for Māori bodies, spirits and minds both individually and collectively.

Recommendations

- That funding be made available to establish a specialised Māori Centre for Research Excellence across the cancer continuum.
- The the NZ government develops and invests in the implementation and evaluation of a whole-of-government national action plan to address the commercial determinants of health by 31 December 2018.

15. Intergenerational trauma and patterns of harm

The racist processes of colonisation have had and continue to have a profound intergenerational impact on Māori. Māori commentators have argued that experiences of successive and continued systematic and prejudicial legislation have had detrimental consequences for Māori across a number of intersecting determinants of health which include economic, political, social, and educational sectors (Mikaere, 2011; Taonui, 2010). The transmission of intergenerational trauma is associated with negative historical events where Brave Heart (2003) defines historical

trauma as the “cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences” (p. 7).

Chronic exposure to unresolved trauma and stressful events across generations have exacerbated perpetration, victimisation, re-victimisation and emotion-focused coping methods such as problems with alcohol and substance abuse creating cycles of intergenerational abuse, trauma and patterns of harm. Māori men, women and children are negatively overrepresented in our suicide and mental health statistics, justice system, child welfare systems and family violence statistics where connections between addiction difficulties and adverse childhood experiences have been recognised (Family Violence Death Review Committee, 2016; Lawson-Te Aho, 2016; Mikahere-Hall, 2016)

Navigating through the accumulated effects of colonisation and racial prejudice is a collective experience for Māori with long and enduring psychological, emotional, social and spiritual effects. These effects remain unresolved and embedded in many whānau systems where intergenerational patterns of trauma persist culminating in whakapapa (layered-generational) trauma (Hall, 2016; Mikahere-Hall, 2016) due to inadequate interventions and responses from successive governments.

The western health system has failed to respond adequately to Māori suffering. Failing to act has led to the continued perpetuation of trauma where offender/victim cycles are left destined to repeat themselves. The failure to provide adequate care is a clear breach of *CERD*. Calls for government action are now urgent (Libesman, 2007). The government needs to invest in Māori-led solutions to disrupt intergenerational trauma, violence and patterns of dysfunction and support indigenous solution-oriented approaches (Kruger et al., 2004).

Recommendations:

- That the NZ government invest in a whole-of-government long-term intergenerational action plan to address and eliminate intergenerational and unresolved Māori trauma by 31 December 2018.
- That the NZ government remove opportunities for intergenerational trauma and patterns of harm to occur by addressing economic and social disparities experienced by Māori whānau, which currently exacerbate high rates of Māori impoverishment and inter-personal whānau dysfunction.
- That the NZ government remove the systemic barriers that perpetuate cycles of intergenerational trauma and entrapment by responding positively to Māori suffering and Māori led solutions & evaluation initiatives.

16. Māori and seclusion in mental health

When mental health service users are perceived to be mentally unwell and pose a threat to the safety of themselves and/or others, they may be required to engage in legally-mandated compulsory assessment and treatment, irrespective of their wishes. In New Zealand, Māori are 3.6 times more likely than non-Māori to be subject to a community treatment order under the *Mental Health Act 1992*, and 3.3 times more likely to be subject to inpatient treatment orders (2015 figures). The reasons for the high rate of Māori subject to compulsory treatment orders are complex. However qualitative research has indicated that Maori under compulsory assessment and treatment find this experience discriminatory, restrictive and disempowering (Ministry of Health, 2016c).

The use of ‘seclusion’ (shutting people in a room they cannot get out of) is legally mandated under compulsory assessment and treatment, as a last resort, when people pose as a threat to themselves or others. There is an international drive to reduce and, in some cases, eliminate the use of this practice. Seclusion is a potentially coercive violation of service users' human rights and there is substantial evidence that its use has negative consequences for service users, their families, and clinicians. Its use compromises the therapeutic relationship, causes physical harm, can be experienced as traumatic events, and may recapitulate previous experiences of trauma.

In 2015, Māori were almost five times more likely to be secluded in adult inpatient services than non-Māori. Māori were secluded at a rate of 89 people per 100,000 population, and non-Māori at a rate of 18 people per 100,000 (Ministry of Health, 2016c). It has been suggested that ethnic or racial stereotyping of service users by healthcare workers may influence the use of coercive measures such as seclusion and that research investigating the role of service-provider level factors in this regard is required (McLeod, 2017).

Recommendations:

- That the Ministry of Health develop and invest in the implementation and evaluation of an action plan to improve Māori experiences of compulsory assessment and treatment, that includes:
 - an holistic approach to service provision, and
 - the provision of care and treatment in alternative, less restrictive environments.
- That the Ministry of Health ensure representation of Māori with lived experience of mental health care in advocacy, leadership, policy-making and decision-making positions within the mental health sector.

17. Racism in Violence in Whānau

Māori women and children are at higher risk of death and serious harm as the result of violence in their whānau, with Māori men over-represented as perpetrators of violence. Unrecognised violence and the subsequent trauma tamariki (children) acquire becomes an incubator for violence perpetration and victimisation in their adulthood (Family Violence Death Review Committee, 2014; Wilson, 2016)

Violence within whānau (extended families) is destructive, resulting in long-term physical, psychological and social harm (Lamers-Winkelman, 2012; Sugg, 2015; Wilson, 2016). For Māori, violence within their whānau is more than a power and control issue. It involves complex contexts that includes the effects of colonisation, historical trauma, disconnection from their cultural identity and cultural practices, and contemporary disadvantage (Family Violence Death Review Committee, 2016).

Māori women and men face multiple forms of other oppression, including structural and interpersonal racism when seeking help from government services. Ongoing racism Māori encounter is a deterrent to obtaining needed assistance to address the violence. It also contributes to service cultures and providers' practices based on unhelpful and unsubstantiated stereotypes and judgments that results in unmet need for Māori women trying to get help to protect themselves and their children (Family Violence Death Review Committee, 2014).

The failure of government services to respond to Māori women, children and men seeking help with the violence they live with perpetuates the risk women and children live with and the ongoing exposure of children to violence and the transmission of violence across the generations.

Recommendation:

- The NZ government develop strategies to address the interpersonal and structural racism within its health and social services that impede Māori obtaining the help and resources needed to eliminate the violence they experience.

18. Ihumātao

Recently, the New Zealand Government has supported the plans of trans-national corporation Fletcher Residential Limited to build high-priced dwellings on stolen land at Ihumātao, South Auckland. The Government used the discriminatory provisions of the *Housing Accords and Special Housing Areas Act 2013* to establish Special Housing Area 62 (SHA62) on this land.

Despite the strenuous opposition of mana whenua, descendants of the colonist landowners have used the profoundly pro-development provisions of the *Special Housing Area (SHA) Act 2013* to have Puketapapa designated for urban development in 2014. The *Act* fast tracks development of land for building of houses, minimising the rights of indigenous peoples to object, negotiate or disrupt any development proposed under its provisions.

The repeated failures of bureaucratic and political authorities to acknowledge the issues at Ihumātao have left mana whenua with no other option but to resist and oppose the development through peaceful, non-violent, and direct action till all legal and political means available are exhausted. There are multiple strands to mana whenua objections to the proposed development including erosion of cultural/spiritual values, identity damage, economic harms, loss of heritage landscapes and reduction in urban open space. The case is of considerable urgency as the developer Fletcher Residential Ltd has now purchased the property and obtained most of the necessary legal consents to proceed.

The issues surrounding SHA62 were presented at the Permanent Forum on Indigenous Issues in New York in May 2017. Highlighted were a number of grievous breaches against the *Declaration of the Rights of Indigenous Peoples* (UN, 2007). We further argue that despite the claims to the contrary by the New Zealand Government and Auckland Council, there are manifest transgressions against the *Tiriti o Waitangi*, the *International Convention on the Elimination of all Forms of Racial Discrimination* (UN, 1966) (especially General recommendation 23) and the *Universal Declaration on Human Rights* (UN, 1948). It is these breaches that we request that the Committee address in order to uphold our rights as tangata whenua.

Recommendations:

- That the NZ Minister of Housing exercise their discretion under the Housing Accords and Special Housing Areas Act 2013 to revoke the provisions made for SHA 62.
- That the NZ Government and other responsible authorities support mana whenua to establish a sustainable future for the confiscated land.

19.Waitara Lands Bill and Pekapeka Block

The Waitara Lands including the Pekapeka Block were confiscated by the Crown at the start of the New Zealand Land Wars in Taranaki (1860-1863). In 2017, the New Plymouth District Council (NPDC) (Waitara Lands) Bill is currently before the NZ Parliament. This Bill seeks to freehold/sell the lands rather than return them to the original owners, of the Waitara hapū of Manukorihi and Ōtaraua from whom it was stolen.

Institutional racism, the pattern of political institutions giving negative treatment to Māori in relation to their lands, has occurred despite clear recognition by multiple government agencies across generations of the injustice. Governor George Grey acknowledged the injustice as early as 1863. The Government-appointed Sim Commission in 1927 confirmed this view. The Waitangi Tribunal in 1986 said so again. At the recent Māori Affairs Select Committee Hearing in Waitara, held at Owae Marae on February 18th, the Chair, Chester Burrows, said to the whole hearing that the injustice was not in dispute, and the NPDC Mayor and Taranaki Regional Council Chair both agreed.

This current proposed legislation continues a pattern of institutional racism. However, both the current NZ government and the NPDC have the opportunity to discontinue this pattern by returning the lands to the Waitara hapū of Ōtaraua and Manukorihi. This would involve both the government and the NPDC taking responsibility, and acknowledging their historic and present day responsibility for maintaining this injustice.

Recommendation:

- That a full provenance is undertaken of the Waitara Lands, and the lands returned to the Waitara hapū of Manukorihi and Ōtaraua by December 2018.

20.Trans Pacific Partnership Agreement

This Agreement (TPPA) is a trade agreement between twelve countries within the Pacific region designed to facilitate free trade. A number of esteemed elders and practitioners in the field of health and traditional rongoa (medicine) practices were part of a group that initiated WAI 2522 (Reid et al., 2015) – a claim to the Waitangi Tribunal. They called for an urgent inquiry into the Crown's actions concerning the TPPA.

The claimants sought amongst other matters the recognition and protection for mātauranga (knowledge) Māori and rights in respect of indigenous flora and fauna. The claim fundamentally called into question not just the adequacy of the protections given by the intellectual property regime, the protected objects regime, aspects of the education system, the environmental decision-making regime and those parts of the health system that involved rongoa, but also challenged the wider decision-making processes of the Crown, including the way in which the Crown negotiates international instruments on behalf of Aotearoa. The Tribunal's recommendations for changes to the Treaty-making process have not been implemented.

The Waitangi Tribunal (2016) report which, in the truncated urgency process, excluded claimants' concerns over the obligation to accede to the *International Convention for the Protection of New Varieties of Plants (ICPNVP)* (UN, 1961), with respect to intellectual property. While the Tribunal found the exception clause was likely to 'provide a

reasonable degree of protection to Māori interests' in relation to the matters it addressed, the Tribunal did not accept the Crown's claim that nothing in the TPPA will prevent the Crown from meeting its Treaty obligations to Māori. Rather, the full constitutional reach of the Treaty relationship may not be as clearly protected and preserved under the TPPA as it ought to be.

As a number of courts and tribunals before us have noted, the Treaty relationship is not static; it is a relationship akin to a partnership, the precise terms of which are still being worked out. The Tribunal considered that the Treaty exception clause as presently structured may not encompass the full extent of the Treaty relationship, The government has failed to disclose any details over the TTPA, particularly the rights of foreign investors to bring claims against the NZ Government which may have negative effects on the Crown's willingness or ability to meet particular Treaty obligations in the future or to adopt or pursue otherwise Treaty-consistent measures.

Since the findings of the Tribunal further work has commenced by the claimants on the second key focus of the urgent hearing, the claimants' concerns over the obligation to accede to the *ICPNV* intellectual property and access to affordable medicines. After over 30 years of placing these matters squarely before the NZ government, the government is still floundering to find a way that gives protection to the rights of Māori to access their traditional medicines and to protect those medicines from exploitation consistent with its extant international obligations.

Recommendation:

- That the NZ government establish a mechanism to ensure Māori interests as Treaty partners are protected within all Treaty negotiations.

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