Committee on the Covenant on Economic Social and Cultural Rights Shadow Report: Aotearoa New Zealand

14 February 2018

This report builds on the previous report submitted for the Committee on the Elimination of All Forms of Racial Discrimination Shadow Report: Aotearoa New Zealand by a similar coalition of indigenous, academic and other civil society agencies. This report expands the issues regarding racial discrimination related to the International Covenant on Economic, Social and Cultural Rights (ICESCR). Human rights are interdependent, indivisible and interrelated. Economic, social and cultural rights are tied to the right to non-discrimination and in the context of Aotearoa New Zealand also tied to the rights of indigenous peoples.

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

Our collective is interested in the right to health. For Māori (indigenous New Zealanders), hauora and oranga 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 life expectancy, less access to primary health care, less access to treatment, and greater risk of 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).

Economic, Social and Cultural Rights are currently not specifically incorporated into the domestic rights framework in New Zealand (NZ). The government suggests these rights are sufficiently covered by individual statutes, yet economic, social and cultural rights continue to be infringed, specifically if considered in relation to racial discrimination. This is particularly visible in rights related to work, housing and physical and mental health.

This report is structured following the articles of the ICESCR with information provided foreach section where the different supporting groups have gathered data. Given the groups' focus on the health sector, we did not address each of the conventions subsections.

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

1. *Article 1 - Self determination*
    a. Constitutional transformation.
    b. Fulfilling te Tiriti o Waitangi obligations.

2. *Article 2(1) Right to freely dispose of natural wealth and resources*
    a. Ihumātao.
    b. Waitara Lands Bill and Pekapeka block.
3. *Article 2(2) Non-discrimination*
    a. National anti-racism action plan.
    b. Whānau hauā.
    c. Māori health providers.
    d. Māori representation in the media.
4. *Article 3 Equal rights of men and women*
    a. Pay equity for Māori nurses
    b. Migrant and refugee women
5. *Article 6 Right to work*
    a. Māori health workforce.
6. *Article 11 Right to adequate standard of living*
    a. Minimum wage a living wage.
    b. Violence in whānau
    c. Violence in ethnic minority/migrant communities
7. *Article 12 Right to physical and mental health*
    a. Intergenerational trauma and patterns of harm
    b. Institutional racism in health policy
    c. Revoking Māori health plans
    d. Māori and cancer
    e. Migrant and refugee women access to healthcare

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A. Article 1 (1) Self determination

Example 1) Constitutional transformation

The Waitangi Tribunal (2014) - a permanent independent commission of inquiry - 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.

The Māori Iwi Leaders Forum on constitutional transformation, instigated a substantive Māori-led constitutional conversation, which has begun to articulate a Tiriti-based constitution (Matike Mai Aotearoa, 2016) with a target of implementation by 2040. This document articulates a Māori-led view of constitutional self-determination. In 2017 a national gathering of Tauiwi (non-Māori New Zealanders) met to discuss how to support the implementation of the Matike Mai recommendations.

CERD (2017) in their concluding observations recommended the NZ Government without delay, in partnership with Māori, issue a timetable for debating the role of the *Treaty of Waitangi* within constitutional arrangements along with the recommendations of the Matike Mai report. CERD recommended the NZ Government recognise the fundamental right to self-determination of Māori and the obligation to establish shared governance with hapū (sub-tribes).

Recommendations:

- That the NZ Government establish a Working Party or similar mechanism to examine and advance establishing shared governance with hapū by 2021.
- Government resource recommendations from the Aotearoa Matike Mai report and a parallel process for the wider public in preparation for 2021.
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Example 2) Fulfilling te Tiriti o Waitangi obligations

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 natural resources and health (Durie, 1998).

Despite the government's endorsement of human rights treaties and *te Tiriti o Waitangi,* racism has become a normalised part of NZ society. Over the last 178 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 disadvantages Māori while advantaging others. Such racism has taken the form of inappropriate action or inaction in the face of Māori needs and aspirations.

The implementation of the *Treaty of Waitangi/ te Tiriti o Waitangi* and the treaty principles remains symbolic in a number of legislative and policy domains; especially natural resources and the distribution of whenua (land). According to the Crown Minerals Act 1991 the government owns all naturally occurring petroleum, radioactive minerals, gold and silver in NZ. Minerals in Māori owned land are also owned by the government and can be exploited using the Crown Minerals Act. Te Tiriti needs to be fully incorporated in all legislation including consultation and engagement processes.

A recent analysis by Came, Cornes and McCreanor (2018) of public health policy from 2006-2016 showed only 12 policy documents out of 49 developed by the Ministry of Health mentioned the Treaty/te Tiriti and/or treaty principles. The references were categorised from rhetorical, aspirational, practical through to substantive. The majority of the references were at the lower level of rhetorical or aspirational statements. Health policy needs to be strengthened to fulfil the government's obligations under te Tiriti.

Recommendations:

- All social and economic policy needs explicitly articulate how it fulfils the NZ government's *te Tiriti o Waitangi* obligations - detailing how policy addresses each article or provision of the Māori text - to inform prioritisation and investment decisions.

B. Article 2 (1) Right to freely dispose of natural wealth and resources

Example 1). Ihumātao

Recently the NZ government supported the plans of transnational corporation Fletcher Residential Ltd to build high-priced dwellings on confiscated 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 (those with customary authority), descendants of the colonist landowners have used the profoundly pro-development provisions of the *Special Housing Area (SHA) Act 2013* to have Puketāpapa designated for urban development in 2014. The purpose of the *Act* was to fast track land developments for building 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 and at CERD in August 2017. Highlighted were a number of grievous breaches against the *Declaration of the Rights of Indigenous Peoples* (UN, 2007). We further argued to CERD in August 2017 that despite the claims to the contrary by the NZ Government and Auckland Council, there are manifest transgressions against te *Tiriti o Waitangi*, the *ICERD* (UN, 1966) (especially General recommendation 23) and the *Universal Declaration on Human Rights* (UN, 1948). CERD endorsed these claims in its report to the NZ Government and recommended new processes of negotiation with mana whenua to remedy the grievances.

More recently, we have appealed the decision from Heritage New Zealand Pouhere Taonga to grant the developer Archaeological Authority to modify and destroy sites of importance and significance to mana whenua and the local community. The hearing is scheduled for May 2018 and our efforts will be redoubled leading up to this time. As well as approaching ICESCR we are following up with our government on the recommendations from CERD and the support from PFII, we will lay a complaint on the grounds of corporate unethical behaviour with the OECD National Contact Point for Aotearoa New Zealand and continue our work with the NZ Government and the corporation directly. The corporation itself will therefore come under increased scrutiny for the fact that it has no code of ethics and that it is more than 60% foreign owned by manifestly unethical and criminal banks including HSBC, Citigroup, Morgan Chase and Commonwealth Bank of Australia all of which have major convictions for Libor (or equivalent) cheating.

In terms of the ICESCR the NZ government is in breach of Articles 1.1, 1.2, 1.3; Articles 2.1, 2.2; Article 5.1, 5.2; and Article 25. It was responsible for the confiscation and subsequent sale of the land in question in 1863 and for the passing of the SHA Act in 2013 which enabled the sale of the confiscated land to Fletcher. In doing so it initially rendered mana whenua landless and then in 2016, they were without legal avenues to remedy the dispossession of their lands and other resources. It is these breaches that we request that the Committee address in order to uphold our rights as tangata whenua (first people of the land).

Recommendations:

- That the NZ Government disestablish SHA62 at Ihumātao.
- That the NZ Government and other responsible authorities support mana whenua to establish a sustainable future for the confiscated land.

Example 2). Waitara Lands Bill and Pekapeka Block

The Waitara Lands including the Pekapeka Block were confiscated by the Crown at the start of the NZ Land Wars in Taranaki (1860-1863). In 2017, the New Plymouth District Council (NPDC) (Waitara Lands) Bill completed its second reading 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 2017 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.

Article 2 (2) Non-discrimination

Example 1) National anti-racism plan

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. State parties undertake to guarantee that the rights enunciated by the ICESCR will be exercised without discrimination of any kind to race, colour, sex, language, religion, sexuality, political opinion, national or social origin, property, birth or other status. NZ continues to lack a national action plan to end institutional racism. CERD (2017) in their recent concluding observations noted their concern about the absence of a national plan. This absence impacts the exercise of economic, social and cultural rights free from discrimination.

A national plan to appropriately document and eliminate racism would provide a focus for government and civil society action, enable the monitoring of progress towards ending racism, and could make a contribution to honouring te *Tiriti o Waitangi* obligations to Māori.

To this end, Came and McCreanor (2015) have developed four evidence-based pathways that could structure a NZ national strategy. 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 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.

Recommendations:

- That the NZ Government resource a nation-wide conversation about how racism manifests and how all forms of racism may be constructively interrupted.
- That the NZ Government develop and invests in the implementation and evaluation of a whole-of-government national action plan to eliminate institutional racism by 31 December 2018.

Example 2) Whānau Hauā

Approximately 1 in 3 Māori in New Zealand are whānau hauā (Māori with a disability). Whānau hauā are disproportionately represented in negative health and social outcomes (Ministry of Health, 2015b). In 2013, 68% of disabled Māori adults had income of $30,000 or less (Statistics New Zealand, 2015). Detailed data on whānau hauā is not readily available in relation to health and social outcomes. This lack of data compromises the responsiveness of policy and the purchasing of essential social services.

Accessible housing options remain a significant issue for whānau hauā . Due to the lack of modified state houses and affordable and accessible rental properties some whānau hauā are placed in rest homes designed to serve older adults (Spink, 2016).

Emerging research by Hickey and Wilson (2017) shows there are significant barriers to whānau hauā 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 NZ 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 excluded whānau members from working within the household as paid 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 hauā representation in decision-making roles in relation to disability and health 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 hauā to enable the identification of health needs and aspirations to inform policy and service delivery.
- That NZ Government policy be reorientated 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
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Examples 3) Māori health providers

Public institutions within NZ have long been accused of monoculturalism and institutional racism (Came, 2012; Jackson, 1988; Ministerial Advisory Committee, 1988). Both generic providers and Māori providers are contracted by the government to deliver social services. The rhetoric of the NZ government procurement policy (Controller and Auditor-General, 2008) and health policy (Ministry of Health, 2016b) established 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) 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 time frames; 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 government 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 by December 2018

- That, across the public sector agencies such as the Health, Quality 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 funding which is published online and consistently followed;
    - Make the application of prioritisation guidelines mandatory for investment and disinvestment decisions and ensure government officials have access to the relevant training to apply these guidelines; and
    - Ensure a consistent approach to the allocation of cost of living and/or Forecast Funding Track across providers by December 2018
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Example 4) 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 negatively (Hokowhitu, & Devadas 2013, Gregory, et. al. 2011). 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 & Shearer, 2009). This steady flow of negativity affects non-Māori New Zealanders and fuels fear and resentment of 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). As such Maori face higher rates of discrimination in the workplace as well as access to work, housing and health based on the stereotypes generated by the media.

Recommendations:

- That the NZ Government set up quality assurance mechanisms to routinely and 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.

C. Article 3 — Equal rights of men and women

Gender pay gap

According to the Article three ICESCR signatories need to ensure the equal right of men and women in the enjoyment of all economic, social and cultural rights. The 2017 report on *Empirical evidence of the gender pay gap in New Zealand* produced by the Ministry for Women found that:

> … female employees on average receive a lower wage than their male counterparts – $25 per hour compared to $29 per hour. In terms of personal characteristics, females in our sample are marginally older and there are minor *differences in the ethnic makeup across the genders* (with a little more Māori females than males; and a little less Asian females than males in the workforce) (Pacheco Li & Cochrane, 2017, p. 12, *emphasis added*).

While women generally earn less than men, non-white women also earn less than their white counterparts. Pacific women rank lowest in terms of pay equity.

Recommendations:

- The NZ Government takes action to ensure pay parity for women in New Zealand regardless of ethnicity by December 2018.

Example 1) Pay equity for Māori Nurses

Māori whānau (extended families) often have complex health needs and experience considerable socio-economic disadvantage. Successful relationships and health outcomes require tailored interventions from health practitioners skilled in western medicine and te Ao Māori (the Māori world). Māori nurses are critical to successful Māori outcomes for whānau, hapū 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 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 (1989, p. 7)'.

Pay disparities seem to be the unintended consequence of the ways healthcare is currently funded by the NZ Government, which fails to address the differences in infrastructure investment required for Māori versus other larger health providers. 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 NZ Nurses Union have lobbied for structural discrimination, as manifested in pay disparities, to be urgently addressed. They have also previously raised this issue at multiple United Nations forums and committees. CERD (2017) in their concluding observations noted their concern of reports that qualified Māori nurses receive significantly lower pay.

There remains 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 district health boards and other parts of the health sector. Entrenched pay inequities are now affecting the retention and recruitment of nurses into Māori health. 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.
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Example 2) Migrant and refugee women

Migrant and refugee women continue to face discrimination in their access to economic and social rights, including discrimination in the workplace, pay inequity and lack of access to employment. According to Shakti (2017) "limited knowledge of English, varied English accents, vernacular names (non-English), visa status which is often linked to educational opportunities and lack of childcare support are but some of the challenges that increase ethnic minority women's vulnerabilities" (p. 2). Migrant and refugee women also face discrimination in access to social welfare, education and housing. Service providers need to be culturally competent in order to serve the ethnically diverse communities within New Zealand.

In 2017 the government introduced two remuneration thresholds for applicants applying for residence under the skilled migrant category. One was set at the New Zealand median income of $48,859 a year for jobs considered skilled and the other threshold was set at 1.5 times the New Zealand median income of $73,299 a year for jobs that are not currently considered skilled but are well paid (Woodhouse, 2017).

Considering the overall gender pay gap (Pacheco, Li and Cochrane, 2017) as well as the lack of pay equity for female dominated professions, migrant women are disproportionately affected by the changes to the skilled migrant category. Migrant women earning $20 an hour in 2017 would have been considered mid-skilled, as the occupation is level 2 on the Australia New Zealand Classification of Occupation and the pay was above the existing threshold of $19.97. However as of January 15th 2018 they would be classified low skilled, unless their pay increased to the above new threshold of $20.65. In order to secure the economic and social rights of migrant women changes in immigration tied to work and income need to consider the gender inequity that currently exists in New Zealand.

Recommendations:

- That the NZ Government invest in tailored interventions to facilitate equal access to employment and representation of ethnic minorities in the workforce.
- That the NZ Government prioritise funding for culturally competent service providers that work in the intersection of racial and gender discrimination.
- That the NZ Government ensure that migrant women and ethnic minority women are included in all data collected on pay equity.

- That the NZ Government monitors pay (in)equity and the gender gap in relation to immigration changes related to income thresholds.

E. Article 6 — Right to work

Example 1) Māori health workforce

Employment for Māori is important for whānau to achieve their aspirations. In 2017, Māori (in the working-age population) continue to be more than twice as likely to be un- or underemployed (i.e. paid to work one or more hours per week) (Statistics New Zealand, 2018). The health sector is a major employer of workers and Māori are high-users of the health system.

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, by 2028, will 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. 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.

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 by December 2018
- That the Ministry of Health establish a single repository for Māori health workforce data to enable monitoring by December 2018

I. Article 11 — Right to an adequate standard of living

Example 1) Minimum wage - a living wage

The enjoyment of just and favourable conditions of work provides fair wages for all workers, that is equal remuneration for work of equal value without distinction of any kind. For women this means conditions of work not inferior to those enjoyed by men. Equal pay for equal work is a key component to realising economic, social and cultural rights. This includes a living wage, safe and healthy work conditions, equal opportunities for promotion and

professional development including appropriate leisure and rest time as well as paid holidays. Safe and healthy work environment also refers to institutions and work providers that recognise and honour te *Tiriti o Waitangi*.

Currently the minimum wage in NZ is $15.75 an hour if you're over 16 years of age (New Zealand Government 2017). This does not reflect the real cost of living in New Zealand with rising rents due to the housing crises and the increasing costs of food. The living wage concept is a response to concerns about adult and child poverty and inequality generally in New Zealand (King and Waldegrave, 2014). The living wage is $20.20 an hour (Living Wage Aotearoa New Zealand, 2017). It is an hourly rate calculated so a worker can pay for the necessities of live and can participate as an active citizen in a community (Mahoney and Gilbertson, 2013). If covers the basic expenses of a worker and their family such as food, transportation, housing and childcare. Adopting the living wage will advance the realisation of economic social and cultural rights for many New Zealanders, particularly Māori who are over represented in low paid occupations.

Recommendations:

- That the NZ government align the minimum wage to the living wage as calculated annually by the New Zealand Family Centre Social Policy Unit.

Example 2) 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 (Ministry of Health, 2015). 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 is destructive, resulting in long-term physical, psychological and social harm (Sugg, 2015; Wilson, 2016). For Māori, violence within their whānau 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. The 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 violence in their lives perpetuates the risks for women and children and the ongoing exposure of children to violence and the subsequent transmission of violence across the generations.

Recommendation:

- The NZ Government commission an inquiry into barriers to Māori accessing essential health and social services including examining inter-personal and structural racism by December 2018.
- The NZ Government secure cross-party political support for systemic solutions to mitigate the barriers identified by the inquiry by December 2019.
- The NZ government invest in the systemic solutions and monitor progress in their implementation.

Example 3) Violence in ethnic minority/ migrant communities

According to a report by Shakti Community Council migrant and refugee women remain seriously "underrepresented, marginalised, discriminated against and subjected to various forms of violence and oppression" (Shakti, 2017, p22). The discrimination they face is based on their language skills, social and economic isolation (including limited access to the job market) as well as cultural barriers. As such migrant and refugee women currently do not enjoy socio-economic and political equality.

> Forced marriage, under age marriages, female genital mutilation (FGM) and honour based violence are some of the practices that happen within New Zealand based communities. There are also cultural practices such as dowry, polygamy, patriarchy and the culture of male privilege all of which put women at further and increased risk of family violence (Shakti, 2017, p24).

While the government is signatory to different human rights conventions and declarations as detailed above family and gender violence continues to be a problem (NZFVC, 2017). Racial discrimination in the legal system and amongst service providers contributes to compromised access to justice for migrant and refugee woman.

Recommendations:

- Strengthening NZ legislation for practices such as forced and underage marriage, developing frameworks that recognize practices such as dowry, FGM, honor based violence and can thus offer legal pathways for migrant women to seek justice.
- Passing and implementing the Marriage (Court Consent to Marriage of Minors) Amendment Bill, 2017 - which was drafted in order to protect girls and women from forced marriage
- That the NZ Government invest in migrant and refugee women led groups and initiatives that have worked historically and continue to work on family violence
- That the NZ Government strengthen and introduce specific cultural competency training for police, judges and service providers around working with migrant and refugee women.
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J. Article 12 — Right to physical and mental health

The outcomes of racism are manifest in the significant and enduring disparities in economic, social well-being and health between Māori and non-Māori (Marriott & Sim, 2014; Robson & Harris, 2007). Approximately 140 health-related deeds of claim (WAI 2575) connected to Crown Ministers and/or government officials' breaches of te Tiriti are currently before the Waitangi Tribunal (Isaac, 2016). Many of these claims relate to government inaction in the face of systemic health inequities between Māori and non-Māori (Marriott & Sim, 2014;

Robson & Harris, 2007). The NZ Government needs to redress past breaches and ensure no further breaches of te Tiriti occur within the health sector. This will best be enabled through a system-wide approach focusing on: health policy, human resource practices, and sector-wide quality assurance systems.

International and New Zealand research demonstrates the detrimental impact of discrimination and racism on physical and mental health (Paradies et al., 2015). 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 social, economic and psychological indicators of well-being. They found that 43% of the sample reported experiencing 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.

Recommendations:

- That human resources strategies be strengthened to ensure new government 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 state sector by December 2018, and engagement that includes measurable outcomes for service delivery.

Example 1) 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 wellbeing which include economic, political, social, and educational sectors (Mikaere, 2011; Taonui, 2010).

The transmission of intergenerational trauma is associated with negative historical events. 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 has 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 *ICESCR.* 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 historical racism, uneven access to the determinants of health and through good faith and timely engagement with the Waitangi Tribunal reconciliation processes

Example 2) 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. Institutional racism in health policy compromises Article 12 ICESCR - the right to health.

CERD (2017) in their concluding observations noted Māori needs are not adequately integrated in health policies or in the administration of health services. Likewise CERD noted their concern at reports of structural bias in the health care system; whereby Māori providers are marginalised and their input into policy decisions is discounted.

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. These sites of racism may be present in the development of other social and economic policy in New Zealand.

Came, Cornes, McCreanor and Coupe (forthcoming) undertook a study of senior Māori and Pacific leaders experiences of being part of government policy advisory/reference groups. Their qualitative study found that within such monocultural settings it took effort for the leaders to establish credibility, be heard, and navigate meetings. Some leaders negotiated

beneficial outcomes within policy. Others reported witnessing racism in the process and content of policy making, and a strong denial of Māori and Pacific knowledge and intelligence. For example, Māori participants reported raising issues and ideas that were not recorded by (government) note takers or acknowledged by those chairing meetings.

Recommendations:

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

Example 3) Revoking 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 inequities 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 by December 2018, 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 generic health providers develop, implement and report on Māori health plans by December 2018, and that the contracts with these providers including penalties for non-performance or non-compliance.

Example 4) Māori and cancer

Cancer is a significant health issue in Aotearoa however the stark, sustained, disproportionate and unjust burden of this disease on Māori is the human rights issue that is most distressing (Robson, Purdie, & Cormack, 2006). Māori have the right to monitor crown actions and inaction and yet the NZ health system is more likely to fail Māori across multiple points and levels of the cancer continuum, resulting in higher incidence and mortality rates (Cormack, Robson, Purdie, Ratima, & Brown, 2005; Hill et al., 2010). 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).

Although Māori cancer survival has multiple complex drivers including level of co-morbidity and stage of diagnosis, the differential treatment options, access, and timeliness found across different regions and numerous cancer types is most concerning. These differences are incremental and accumulating and contribute to the overall cancer burden (Hill, Sarfati, Robson, & Blakely, 2013; Signal, 2016;). Ethnic differences in treatment pathways are clearly indicative of inferred social standing.

Māori cancer burden can also be attributed to higher incidence rates and Māori communities are saturated with modifiable ill-health determinants. Cancer risks include household overcrowding, lower education and health literacy levels, mental health challenges and commercially driven carcinogens such as tobacco, alcohol and unhealthy food. A relatively new concept within the cancer risk reduction space is the role of commercial determinants and their operation within the trade and political economy (Kickbusch, Allen, & Franz, 2016). Given there is increasing excess incidence and mortality in several obesity related cancers, this particular space needs targeted attention (Teng et al., 2016).

From a kaupapa Māori viewpoint these wrongdoings are not just impacting Māori bodies. Our holistic understanding of the world and ourselves within this world means racism within the cancer continuum has cosmological and intuitive repercussions. The impact of racism doesn't just insult Māori bodies, it assaults mana (dignity), wairua (spirit), mauri (life-force) and whakapapa (genealogy) (Goza, 2017). The entire cancer continuum has failed Māori whilst privileging non-Māori adults, and the government is responsible for it. 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 allocated to establish a specialised Māori Peoples and Cancer Research centre, based in a kaupapa Maori university.
- 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.

<u>Example 5) Migrant and refugee women and access to healthcare</u>

For migrant and refugee women, access to health care and well-being continues to be a challenge. Some women's lack of knowledge of English as well as the lack of culturally appropriate information/ services available. Migrant and refugee sex-workers face more obstacles than other groups, because their work involves higher health risks but also because of overall discrimination against sex workers. In order to get information in different languages women face extra costs and longer waiting periods (Shakti, 2017).

Legal and residential status affects access to healthcare in additional to financial cost for issues such as dental care (Shakti, 2017). Migrant women who are not permanent residents (non-PR status) cannot access government subsidized healthcare, such as maternity care. Increased cost for health care results in migrant women not seeking health care because they fear not being able to pay the costs, further resulting in lower health outcomes for this already vulnerable group. (Shakti 2017).

In regard to reproductive rights, many migrant women continue to be less aware of their rights in New Zealand. Premarital sex, unwanted pregnancy and abortion are often considered taboo and access to abortions of non-permanent residents are not covered under medical insurance and result in higher costs for migrant women (Shakti 2017).

Recommendations:

- Improve the numbers of culturally competent health providers and removing hidden costs for migrant and refugee women
- Increase training for health practitioners and increase the representation of migrant women in the health sector
- Increase culturally diverse reproductive rights programs
- Increase funding for maternity care for migrant women without citizenship or permanent residency

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