Maori land: Maori health

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LAND IN MAORI TRADITIONAL SOCIETY

Prior to European settlement of New Zealand, Maori people had occupied the land for hundreds of years. Their customs, similar to those of other Polynesian peoples of Pacific islands, recognised how rights to land were obtained, and by whom land was rightfully held. Generally a right had been asserted by an identified ancestor in one or more of a number of ways: discovery and subsequent naming; inheritance; conquest; settlement for more than one generation; exchange of land for other treasures; or as a gift. To establish a right to land usually required a sound knowledge of the history of the place and the resources associated with it; the events that occurred there; and tracing one's ancestry to show a connection with the people and events from whom the right to hold the land had been derived.

The relationship of families and sub-tribes with land and other resources was integral with Maori creation beliefs, the deeds of ancestors, and other events told in traditions. It was reinforced by place-names and sites of importance, and passed on through generations. All of these, including rights to hold ancestral land, and to exploit other resources (such as fisheries and forests), were essential to the Maori's sense of identity and belonging, and to their survival.

Land was the sacred trust and asset of the people as a whole, a communally owned bonding agent. Families and sub-tribes were alert to protect their land and other resources, quick to recognise threats and challenges, and equally adept at taking advantage of an opportunity. The Maori's relationship with his ancestral land was more than one of ownership; it had a spiritual element too, based on the traditional concept of the origin of humanity, deriving from the loving union of the earthmother with the skyfather.

Maori customary title to land had a stabilising effect, because land could only be owned by those who actually occupied and worked it, by hunting, fishing or cropping. All claims by others had to be resisted successfully. Those who let their fires become cold lost their rights permanently after a lapse of more than one or two generations.

Tribes and sub-tribes were integrated communities, joining in activities such as hunting, cropping, cooking, weaving mats and clothes, and defending their lands. Land was necessary for economic survival, contributing to sustenance, wealth, traditions of resource management. It strengthened family and sub-tribe solidarity, and added value to personal and tribal identity, as well as to the well-being of future generations.

Land also had spiritual qualities that transcended utilitarian considerations. The land bore names which recorded the histories of the people who had lived there for hundreds of years, histories of occupation, of conquest by war, and of possession by virtue of inter-tribal marriages.

There was no land for which there were not claimants. There was no hill or river that was not known, and whose history could not be recounted. Loss of land was loss of that part of life which depended on the connections between the past and the present, and the present with the future.

MAORI HEALTH IN TRADITIONAL TIMES

In traditional times, the life of Maori was a struggle. Food gathering occupied much time, and often required lengthy expeditions away from home. Even then variety was not assured. Meat and fat were not regular dietary items, and cannibalism may have been, at least in part, a consequence of that deficiency. With a climate far from tropical, protection from the elements was limited, clothing not always adequate, and the benefits of an open fire were diminished somewhat by excessively smoky surroundings.

Maori life expectancy was short, only 25 to 30 years. Maori experienced low birth rates, high rates of degenerative diseases such as stomach and intestinal tumours, marginal (if not inadequate) food supplies, pneumonia and other respiratory diseases. Inter-tribal wars were also a cause of many deaths. Skeletal studies indicated no epidemics, few chronic diseases such as tuberculosis, no debilitating parasites, no heart diseases, no cancer, and few fractures. There were infectious diseases prior to European contact, but contagion was apparently contained. Even the highly contagious leprosy did not lead to widespread infection.

Early explorers were impressed by the stature of the people they met. In 1769 James Cook concluded that Maori were a healthy race, remarking on the great number of elderly men, many of whom by the loss of their hair and teeth appeared to be very ancient, yet none of them was decrepit; and though not equal to the young in muscular strength, they were not behind in cheerfulness and vivacity.

EUROPEAN SETTLEMENT AND THE TREATY OF WAITANGI

Europeans first visited New Zealand on voyages of exploration. Cook left potatoes and turnips, which became major items in Maori diet and industry. The early explorers were followed by traders, whalers and sealers. Maori soon began trading with them, exchanging food for iron tools: nails, chisels, hoes, hand-axes and scissors, and later, muskets. New Zealand timber and flax, and seal fur and sea-mammal oil, were in demand in Europe.

In 1814 the Church of England Missionary Society formed the first organised European settlement in New Zealand, bringing European items and skills, as well as the Gospel. Wesleyans followed in 1822, and Catholic missionaries from France in 1838. There were also ships searching for flax, timber, seals, and foodstuffs. Undischarged convicts on the run, and other bad elements, came from New South Wales. The timber industry grew in the 1820s, and whaling brought many more Europeans in the 1830s.

In 1832 a British Resident was appointed to protect well-disposed settlers and traders, to guard against the exploitation of Maori by Europeans, and to recapture escaped convicts. But without resources he was not effective.

By 1840 there were 2000 Europeans in New Zealand. Many of them had already caused trouble in New South Wales, but New Zealand was too far from Sydney for effective policing from there. To impose some order on what was becoming a lawless settler colony, and on warring tribes, the British Government sent a naval officer to negotiate a transfer of sovereignty from the Maori chiefs to the British Crown. A treaty was made (the Treaty of Waitangi) by which the chiefs ceded sovereignty to Queen Victoria; she guaranteeing their chieftainship of their land, forests, fisheries, and other treasures so long as they wished to retain them (giving the Crown exclusive rights to their purchase); and granting the Maori people royal protection, and the rights of British subjects.

The Governor proclaimed British sovereignty, and British colonisation proceeded. Although it had been explicitly decided that New Zealand was not to become a repository for convicts, and immigration from Australia was not officially encouraged, most of the early settlers drifted across from Australia, rather than emigrated from Britain. Assisted emigration of respectable poor from Britain was an official priority, as were military pensioners. By 1858 the number of non-Maori in New Zealand was 59 000, more than the 56 000 Maori; and by 1881 there were about 500 000 non-Maori.

DEPRIVAL OF MAORI LAND

The exclusive right of Crown purchase in the Treaty of Waitangi had been intended to protect Maori from unscrupulous land-dealers, and to fund emigration by creating a price differential. Although the Crown had an active land-purchase policy, there was pressure for direct purchasing, and land-brokers were soon active. Some factions of Maori supported selling their land, and others supported holding it. The Crown purchased land from tribal chiefs, some of whom, it was later claimed, had no authority to sell it. There were also complaints that the prices paid were too low. Some Maori were willing to sell their land direct to purchasers.

Disputes arose over who had the right to sell land, and over how much had been sold, leading to outright hostilities in some cases. Land sales became a matter of such widespread concern that they threatened Maori resources and control. Maori opposition to land sales was countered by armed troops, and the punishment was confiscation of tribal lands. Some 3 million acres were confiscated from supposed rebels, although much was returned later.

In the 1860s, the settler parliament also passed laws for transferring ownership of Maori land from tribal collectives to individuals, largely doing away with customary land titles, and freeing up land for sale. The Native Land Court was set up to determine ownership. The Court adopted a protective role towards Maori owners in the alienation of their lands. Even so, out of nearly 66.5 million acres, by 1896 only 11 million acres remained in Maori ownership.

The loss of Maori land continued through the 1890s and early 1900s, in which another 3.25 million acres of Maori land was purchased; and another 2.3 million acres between 1911 and 1920. Of the 4.7 million acres remaining in Maori hands in 1920, 0.75 million was leased, and another 0.75 million was unsuitable for farming. The remaining land supported a mixture of sheep farming, small family dairy herds, maize cropping, extraction of gum, and subsistence gathering of seafood and of eels from inland waterways.

The loss of land also had the effect of undermining the social links between families and within tribes, Maori identity and well-being. Many Maori lost contact with their ancestral land. Perhaps as many as 30 or 40 per cent of adult Maori no longer have actual interests in traditional land; and where ownership remains, a system of equal succession by all children has led to high fragmentation. From this base Maori struggled to survive in a marginal economy.

MAORI HEALTH AFTER SETTLEMENT

Prior to settlement by Europeans, Maori had been protected from many minor childhood illnesses by New Zealand's isolation from the large population centres of the world. Bacterial infections were not uncommon, but viral diseases were new. Although measles, mumps, and influenza were regarded in Europe as incidental afflictions with no serious medical implications, they became devastating when introduced to New Zealand. Adults as well as children were affected, and in some areas whole settlements were annihilated. Mortality rates

were high. Measles, influenza, whooping cough, typhoid, scarlet fever, and mumps all took their toll. Tuberculosis was particularly endemic. By the middle of the 19th century it was widely prevalent, and crowded living conditions promoted its rapid spread.

As early as the 1820s, Maori who were in contact with Europeans were subject to epidemics of influenza and whooping cough, and some venereal disease. From the immigrations of the 1840s on, Maori became more exposed to influenza and measles, to which they were vulnerable due to their overcrowded, damp, and unhygienic living conditions.

The large-scale alienation of Maori land that followed had negative implications for Maori well-being, which was so closely associated with tribal land ownership. Defeat in war, confiscation of land, and denigration of core features of Maori culture led to loss of self-esteem, as well as reduction in their capacity to produce food for the market or even for their own survival. Few tribes had sufficient land to meet their future economic needs, and some were left virtually landless, lacking a place where they could feel secure, confident and supported, connected to their heritage. Maori social unity began to crumble. With the loss of land and the individualisation of titles, the need to remain together and to provide mutual support lessened. An important foundation for health, the family, was weakening at time when it was most needed.

By 1857 the population had already declined from a high point of 110 000 to around 56 000. A diet of potatoes and little else was simply not compatible with life, and gave scant protection against new infectious diseases such as measles, tuberculosis, and influenza. The population decline continued, and as mortality rates soared, so land holdings decreased. By 1896, the Maori population had declined further to less than 42 000. Depopulation was greatest where land alienation had been most extensive. Loss of land had more than economic implications. In addition to loss of income and livelihood, because personal and tribal identity was closely linked to the land, loss of ancestral land had adverse psychological effects as well.

Tuberculosis was also a threat. Even into the middle of the 20th century it was endemic within many Maori communities. Although lack of natural immunity was probably a determining factor, the high toll from infectious diseases was also related to changes in lifestyle– a move to low-lying villages, different foods, association with immigrants from Europe, less exercise, and overcrowding.

By the early 1900s considerable progress in health reform had been made –building latrines, destroying insanitary houses, and deployment of Maori health nurses. Longer term improvement in Maori health depended on a gradual development of immunity to the more common viral diseases. Poverty and poor housing remained causes of the continuing high infant and maternal mortality rates, of recurrence of typhoid fever, and of prevalence of tuberculosis.

Following urbanisation in the 1950s, additional health risks emerged with the adoption of yet newer lifestyles. Reduced family support, alcohol and drug misuse, smoking, high-risk leisure pursuits, over-eating, and long-term unemployment all became new major risks to Maori health.

When there is a loss of the resources necessary to sustain well-being, and a loss of standing in terms of full participation in society and the economy, health is also threatened. Mate Maori leads to an affliction said to be related to spiritual causes, and requires the intervention of a traditional healer. It may take several forms, physical and mental, and various illnesses may be ascribed to it. Increasingly it has become a focus to explain emotional, behavioural and psychiatric disorders.

Good health requires more than health services. Society should be supportive of the right of Maori to live as Maori, with a secure and meaningful identity. To enjoy good health and a sense of well-being, Maori people should be able to live comfortably as Maori, for which an association with their ancestral land is valuable for many.

RECOVERY

By 1900 the threat of extinction of the Maori race had passed, though new threats to health were to emerge, not least considerable losses of servicemen in two world wars, and large numbers of deaths in the 1919 influenza epidemic.

However by 1936 the Maori population had grown to 82 000, and there was a strong positive feeling about being Maori. Now it has reached nearly six times the maximum prior to colonisation: some 620 000 New Zealanders claiming Maori descent.

These days many of the laws of the land have come to reflect Maori perspectives and values. The relationship of Maori and the culture and traditions with their ancestral land have to be recognised and provided for in decisions about management of environmental resources. Particularly regard has to be had to the Maori traditional cultural stewardship of environmental resources.

The law governing Maori customary land is now based on traditional Maori attitudes to land and its importance for future generations, and makes it extremely difficult for ancestral land to pass out of Maori ownership. Multiple ownership is actively encouraged, and improved management structures enable better commercial returns on tribal land. The greater power is now vested in collective decision making, as it had been before British settlement.

In recent decades, considerable areas of former ancestral land have been returned to Maori, and substantial compensation has been paid to tribes on account of historic unjustified confiscations, and other breaches of the Treaty of Waitangi.

Continuing disparities in standards of health between Maori and other New Zealanders are indicators that more remains to be done. The achievement of good health, including good mental health, requires approaches that go beyond the provision of health services. Cultural identity depends not only on access to culture and heritage, but also on opportunity for cultural expression and cultural endorsement within society’s institutions.

Government health policy currently recognises the importance of taking Maori culture and society into account when programs for improving Maori health are being developed. Maori health has been identified as one of four health priorities. Delivery of many government services, especially those associated with health and welfare, has been devolved to Maori authorities. There is active encouragement for Maori health care providers, Maori community health programs are rapidly increasing, and public hospitals are expected to indicate how their services will contribute towards improved health outcomes for Maori. The Mental Health Act recognises the significance of a Maori cultural identity. It requires decision makers to have respect for a person’s cultural and ethnic identity, and recognition of the importance to the patient’s well-being of family and tribal ties.

In these and many other ways progress has been made in fulfilling the expectation that Maori will share equally in the benefits of modern society. It has become accepted that Maori culture and language should be promoted by the State. Although Maori are still under-represented in some professions, and are still over-represented in crime and ill-health statistics, Maori are found in top positions in all areas of national life, including politics, business, sport,

entertainment, the civil and military services, the medical professions, education, the law and the judiciary, the churches, and entertainment. Maori culture and language are widely valued by non-Maori New Zealanders, and by the institutions of the State. There is a publicly funded Maori television channel, a Maori political party, and several Maori radio stations; and also many educational institutions at all levels teaching in the Maori language

The Maori population in New Zealand, about 70 000 in 1840, and now about 620 000, is expected to reach nearly 750 000 by 2021. The life expectancy at birth of Maori, which was about 30 years in 1840, is now 73.2 years for females and 69 years for males, close to those of New Zealanders generally.

The historic loss of Maori land cannot be suggested as the only, or even the main, cause of Maori ill-health over the last 150 years. But in that the extensive loss of their ancestral land deprived Maori of traditional resources of considerable economic value, and of high value to their identity and self-esteem, it was undoubtedly a significant contributor to such pervasive ill-health that only a century ago their very survival as a people was in doubt.

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