Ethnicity & Health

ISSN: 1355-7858 (Print) 1465-3419 (Online) Journal homepage: https://www.tandfonline.com/loi/ceth20

Rangatiratanga and *Ōritetanga*: responses to the Treaty of Waitangi in a New Zealand study

Emma H. Wyeth , Sarah Derrett , Brendan Hokowhitu , Craig Hall & John Langley

To cite this article: Emma H. Wyeth , Sarah Derrett , Brendan Hokowhitu , Craig Hall & John Langley (2010) *Rangatiratanga* and *Ōritetanga*: responses to the Treaty of Waitangi in a New Zealand study, Ethnicity & Health, 15:3, 303-316, DOI: 10.1080/13557851003721194

To link to this article: https://doi.org/10.1080/13557851003721194

Published online: 10 May 2010.

Ethnicity & Health
Vol. 15, No. 3, June 2010, 303–316

Routledge
Taylor & Francis Group

Rangatiratanga and *Ōritetanga*: responses to the Treaty of Waitangi in a New Zealand study

Emma H. Wyeth[a]*, Sarah Derrett[b], Brendan Hokowhitu[c], Craig Hall[c] and John Langley[b]

[a]*Te Roopū Rangahau Hauora Māori a Ngāi Tahu (Ngāi Tahu Māori Health Research Unit), Department of Preventive and Social Medicine, University of Otago, Dunedin, New Zealand;* [b]*Injury Prevention Research Unit, Department of Preventive and Social Medicine, University of Otago, Dunedin, New Zealand;* [c]*Te Tumu – School of Māori, Pacific and Indigenous Studies, University of Otago, Dunedin, New Zealand*

(*Received 30 March 2009; final version received 20 February 2010*)

Introduction. Although opportunities exist for positive experiences in research, Māori in New Zealand, like other indigenous people colonised by Europeans in the nineteenth century, have also been subject to research and associated policies that have had long-lasting negative consequences. Researchers have subsequently been challenged by Māori to conduct research that is acceptable, accountable and relevant. Much of this debate has taken place within the framework of the Treaty of Waitangi, a treaty of cession signed between Māori and British Crown representatives in 1840. Nowadays, health and health research statutes exist that require researchers to respond to the 'principles' of the Treaty. Few practical examples of how health researchers have undertaken this have been published.

Aims. We examine how, in developing a national study of injury outcomes, we responded to the Treaty. Our study, the Prospective Outcomes of Injury Study, aims to quantitatively identify predictors of disability following injury and to qualitatively explore experiences and perceptions of injury outcomes.

Discussion. Responses to the Treaty included: consultation with Māori groups, translation of the questionnaire into *te reo* Māori, appointment of interviewers fluent in *te reo* Māori, sufficient numbers of Māori participants to allow Māori-specific analyses and the inclusion of a Māori-specific qualitative component. While this article is located within the New Zealand context, we believe it will resonate with, and be of relevance to, health researchers in other former settler societies. We do not contend this project represents an 'ideal' model for undertaking population-based research. Instead, we hope that by describing our efforts at responding to the Treaty, we can prompt wider debate of the complex realities of the research environment, one which is scientifically, ethically and culturally located.

Keywords: indigenous; Māori; policy; bicultural; power; injury

Introduction

Like other indigenous populations colonised by Europeans in the nineteenth century, Māori in New Zealand have been subject to research and research-based policies with long-lasting negative consequences (Smith 1999). In common with researchers

*Corresponding author. Email: emma.wyeth@otago.ac.nz

ISSN 1355-7858 print/ISSN 1465-3419 online

DOI: 10.1080/13557851003721194
http://www.informaworld.com

from other former settler societies, researchers in New Zealand have more recently been challenged by Māori to conduct research that is acceptable, accountable and relevant to Māori. Much of this debate has taken place within the framework of the Treaty of Waitangi, a treaty of cession signed between Māori and British Crown representatives in 1840.

Despite past negative experiences, opportunities for positive outcomes for Māori from research do exist. In the twenty-first century, health and research statutes require health researchers to respond to the 'principles' of the Treaty. Yet, to date, few practical examples of how researchers have responded to these principles within the health research environment have been published (Cram *et al.* 2004, Adolescent Health Research Group 2008). This paper examines how, in developing a study of injury outcomes experienced by the general population, we responded to these challenges and opportunities. While much of this paper relies on the particular history and political landscape of New Zealand, we contend that it will nonetheless resonate with, and be relevant to, other health researchers in other former settler societies. Our study, the Prospective Outcomes of Injury Study (hereafter the Study), aims to quantitatively identify predictors of disability following injury and to qualitatively explore the lived experiences and perceptions of injury outcomes with two sub-groups – Māori and non-Māori. The Study has been designed through our efforts to respond to the principles of the Treaty, alongside scientific expectations required of researchers internationally and funders nationally. We do not contend that this project represents an 'ideal' model for undertaking population-based research in New Zealand. Instead, we hope that by describing our efforts, we can prompt wider debate about the complex realities of the research environment – one which is scientifically, ethically and culturally located.

Aims

This paper aims to describe a response from a research team to the 'principles' of the Treaty of Waitangi within the development of a national study of injury outcomes.

We first offer a brief insight into the New Zealand context as it relates to the Treaty. We then outline the emergence of the principles of the Treaty and how these have been adopted within health and disability research legislation, funding agencies, ethics committees and research institutions. We go on to describe the development and design of the Study in relation to these issues.[1] Finally, we discuss the challenges and opportunities for improving our responsiveness to the Treaty as this study progresses.

Early New Zealand society

New Zealand was settled by the thirteenth century by East Polynesian people whose subsequent descendants were early Māori. The introduced Polynesian culture then transformed to a distinctly indigenous New Zealand one in which 'despite tribalism and . . . regional identity, the basic concepts and values . . . were recognised and accepted from one end of the country to the other' (King 2007).

At the time of Captain Cook's visit in 1769, the Māori population was estimated at 100,000 people. European trade had many consequences for Māori, including: inter-racial sexual liaisons; introduced diseases to which Māori had limited or no

immunity; and the acquisition of European goods including alcohol, tobacco and muskets. By the 1830s, Māori armed with muskets wrought havoc on those without them. Coupled with introduced diseases, the Māori population, as a whole, declined rapidly (King 2007). Later, Europeans became involved in tribal wars leading to calls for formal British intervention.

The Treaty of Waitangi

The Treaty of Waitangi, named after the place where it was first signed on 6 February 1840,[2] is a treaty of cession. It reflected two streams of thinking (commercial and humanitarian interests) and thus embodied contradictory aims: provision for British settlement on one hand, and protection of Māori interests on the other (as outlined in the preamble of the Treaty).

The Treaty consists of three articles and was written in both English and *te reo* Māori (the Māori language). The majority of Māori representatives signed the Māori version, which does not directly correspond with the English version. This led to both parties having different expectations of the Treaty. Māori signatories probably thought that their sovereignty was being acknowledged and protected by the Crown, whereas the Crown thought that Māori signatories had ceded their sovereignty to it. The English version essentially states that:

- Article I: Māori cede sovereignty of New Zealand to the British Crown.
- Article II: In return, Māori are guaranteed full exclusive rights of ownership and use of their lands, forests, fisheries and other possessions, but if they wish to sell any of these, it must be to the Crown.
- Article III: Māori enjoy the same rights and privileges as British citizens. (Orange 2001)

The three Articles of the Māori version were, respectively, expressed by the terms *kāwanatanga* (governorship), *rangatiratanga* (chieftainship) and *ōritetanga* (equality). In a modern context this means that the Crown has the right to govern, Māori kin groups have the right to own and manage collective assets and Māori individuals have the same rights and responsibilities as non-Māori New Zealanders. The concepts of *rangatiratanga* and *ōritetanga* are examined in this paper.

Māori society after the signing of the Treaty of Waitangi

As more British immigrated to New Zealand and the Māori population declined, Crown officials had less regard for the Treaty. The years following the signing of the Treaty were turbulent with land-hungry settlers taking land by armed conflict in some regions; Māori depopulation was often used to justify this acquisition. Loss of land, especially by force, made life extremely difficult for those surviving Māori. By 1877, a Supreme Court judgement deemed the Treaty of Waitangi a 'simple nullity' of no legal consequence (Orange 2001).

The Māori population reached its demographic nadir in the mid-1890s. However, from the early twentieth century, the population began to slowly recover (Lange 1999). Part of this recovery was due to the efforts of young European-educated Māori politicians and public health leaders, such as Maui Pōmare, Apirana Ngata

and Te Rangi Hīroa, who worked with Māori communities to improve their living conditions (Lange 1999).

In 1940, the oldest known copy of the Treaty was put on public display. Somewhat symbolically, it was found in a government archive chewed on by rats. As the Māori population grew and became urbanised, the policy touchstone became that of racial amalgamation, which many Māori criticised (Ward 1973). In the 1960s, Māori dissatisfaction was voiced more loudly and effectively than ever before. Māori were numerically stronger and better educated than many previous generations. Things were galvanised by protests over legislation usurping ownership and use rights over remaining Māori land, tours by South African sports teams during the apartheid era, and the decline of *te reo* Māori. By the 1970s, Māori groups had successfully called for definitions of Māori to be less connected with Victorian notions of blood-quantum and more in line with traditional views based on *whakapapa* (genealogy).

In 1975, the Government established the Waitangi Tribunal. This quasi-judicial body could investigate Crown breaches of 'the principles of the Treaty of Waitangi' from 1975 onwards. In 1985, powers of enquiry were extended back to 6 February 1840 (Orange 2001). In 1987, the Court of Appeal interpreted what it believed was meant by the 'principles of the Treaty'. The principles of the Treaty included ideas of partnership, reasonableness, acting in good faith and obligations binding the Crown akin to those of a fiduciary nature (Ruru 2008). As well as a changing international context towards indigenous rights, some argue that a driver for the recognition of Māori rights was the continued increase in the Māori population (O'Regan 2008). Most recently, in the 2006 national census, 565,329 people self-identified with the Māori ethnic group and 643,977 people identified having Māori descent, corresponding to 14.6% and 17.7% of the total New Zealand population, respectively (Statistics New Zealand 2007).

Reference to the Treaty's principles is now made in all manner of legislation, including research policies, requiring researchers to consider Māori and the Treaty. Some researchers feel that these are at odds with good research, that it contravenes the fundamental notion of 'objective science' and researcher autonomy. Descartes provided a blueprint of a scientific model where research is undertaken within a state of 'all things being equal' and where bias is eliminated (Popkin 1999). Many researchers who adhere to this model would find the requirement to consult and examine their research in relation to the Treaty as unjustified, partial and therefore inauthentic.

Key to the notion of understanding research invested in indigenous well-being is the way we conceptualise 'rights'; that is, as either 'individual' or 'collective' rights. In many indigenous communities, including Māori society, rights are constructed in relation to levels of communal structure, whether that be *whānau*, *hapū* (sub-tribe) or *iwi*. Obviously, there is room for the autonomous individual in Māori society, but often the individual reflects an epistemology that foregrounds the rights of the community. In traditional western conceptions of rights, '. . .the autonomous human being is [a] fundamental condition for democratic organization' (Rata 2005, p. 273). In New Zealand, as in most colonised lands, the concept of individual rights pervades our moral, political and legal vocabulary: '. . . we have come this century to conceive all human beings as bearing the inalienable (natural or human) right to

choose individually and equally how to lead their own atomic lives without disadvantaging anyone else' (Goldberg 1993, p. 19).

Such a conceptualisation of rights does not work in most colonised contexts for two reasons. Firstly, many indigenous people do not prescribe to the conceptualisation of rights as an individual notion, as described above, and secondly, there is an imbalance of institutional power. Power structures within colonised societies discriminate against indigenous people to the extent that 'positive discrimination' is seen as necessary to level the playing field. Social movements in the last half of the twentieth century, including the civil rights movement, the feminist movement, gay rights and the decolonisation movement, were all fundamentally based upon an understanding that the White patriarchal system that governed the west (at least) was premised on institutional exclusion to the detriment of these collectives (Nash 2001). Politicisation of Māori collective rights, for example, has sought to improve the well-being and collective determination of Māori, based on tribal challenges through the rallying exclamation of *tino rangatiratanga* (i.e., the right of Māori to collective determination) through the Treaty of Waitangi (Harris 2004).

Although the Treaty of Waitangi itself has not been directly incorporated into New Zealand's law, its transition from 'rat nibbled nullity' to New Zealand's 'founding document' has rightly earned it the title of 'the Māori Magna Carta' (O'Regan 2001). Currently, over 35 statutes, including those governing health and health research, refer to the principles of the Treaty with government bodies being variously required to 'have regard', 'take into account' or 'give effect' to them (Tipene-Matua and Dawson 2003, Ruru 2008).

Health research in relation to the Treaty of Waitangi

Article III of the Treaty underpins the expectation that Māori have equal standards of health as non-Māori and that significant disadvantages are addressed (i.e., *ōritetanga*) (Health Research Council (HRC) of New Zealand 2008). Health inequalities between Māori and non-Māori New Zealanders have been constant and undeniable for decades (Reid and Robson 2007). Currently, Māori men and women live an average of 7.9 and 8.6 years, respectively, less than their non-Māori non-Pacific counterparts (Statistics New Zealand 2008). Advantages of conducting health research that is acceptable, accountable and relevant to Māori include helping gain knowledge towards improving outcomes and reducing such disparities.

Of relevance to this paper, the New Zealand Public Health and Disability Act 2000 states that 'in order to recognise and respect the principles of the Treaty of Waitangi' provision must be made for 'mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services'. Further, the Ministry of Research, Science and Technology (MoRST), which manages the Government's investment in research, science and technology primarily via the HRC (the major purchaser and coordinator of health research), the Foundation for Research, Science and Technology and the Royal Society of New Zealand, states that the goal of research in relation to Māori development should respond to:

> Article II of the Treaty, which relates to rangatiratanga – Māori control of things Māori. It is also a partnership between tangata whenua and the Crown involving respect and

> support for Māori approaches, philosophies and methods in research, and the use of the Māori language, culture and experiences. This goal encourages greater Māori control and participation in research agendas. (Ministry of Research, Science and Technology 2004, p. 7)

In particular, MoRST pays attention to what they call 'Māori Advancement' by focusing 'upon achieving equity and reducing disparities for Māori' relating to Article III (*ōritetanga*) (Ministry of Research, Science and Technology 2004). The HRC uses 'responsiveness to Māori' as a label for the responsibility to consult with Māori according to the Treaty (HRC of New Zealand 2008). This has been a requirement of research-funding applications since 2000 (A. Haggie, personal communication, 15 Sept 2008). Implicit in legislation and policies is an acknowledgement that research involving Māori needs to develop methodologies and processes specific to Māori as a collective, while also acknowledging Māori diversity, if research is to be relevant and meaningful.

Health research funding and ethical requirements

Research of high relevance and benefit to Māori is a priority area for the HRC.[3] The HRC states its commitment to the principles of the Treaty of Waitangi and 'to building both a sustainable Māori health research capacity and long-term research partnerships between non-Māori researchers and Māori groups and communities' (HRC of New Zealand 2008, p. 4).

In New Zealand, health and disability research involving people requires ethical approval before commencing. The objectives of ethical review include: safeguarding the rights and interests of research participants and protecting Māori cultural interests and well-being (Ministry of Health 2006). All investigators are required to demonstrate commitment to the Treaty through the design and conduct of the research. Issues relating to Māori cultural and ethical values should be discussed with Māori, and Māori should be recognised as *tāngata whenua* (Māori that have customary rights in a specific area or region) and indigenous people (National Ethics Advisory Committee 2006).

Host research institutions: the University of Otago

Also of relevance to the Study is the Education Act 1989, which requires schools and universities to form relationships with local *iwi* (tribe(s)). The University of Otago (the authors' employer) sits within Ngāi Tahu's *takiwā* (tribal area). As a result of their Treaty-based relationship the University adopted the Research Consultation with Māori Policy and the tribally mandated Ngāi Tahu Research Consultation Committee (NTRCC) was established to oversee research proposals and their impact, positive or negative, on Article II rights of Ngāi Tahu (University of Otago 2003). This process ensures that Ngāi Tahu have an opportunity to contribute to the development and planning of research in a way that is mutually beneficial to both parties. To our knowledge, this *iwi*-mandated process is unique to the University of Otago and Ngāi Tahu.

An attempt to respond to the Treaty in a study of outcomes for injured New Zealanders

Only in the late twentieth century have researchers begun to empirically consider injury-related disability, and the predictors and outcomes of such disability (van Beeck *et al.* 2007). Injury is now an important component of the Global Burden of Disease work and contributes to 9.8% of mortality and 12.3% of disability internationally (World Health Organization 2008). In New Zealand, injury has also been identified as an important issue for Māori (Langley and Broughton 1998, Ministry of Health 2001, Bismarck 2006, Koea 2008). In 2003, the idea for a study of people's outcomes following injury was conceived by JL, stemming from familiarity with injury research and the emerging political and social thinking about injury-related disability. The developmental study proposed to '[u]ndertake developmental work with a view to preparing a project grant application to undertake research aimed at determining the personal, social, injury and rehabilitation determinants of disability and cost following injury'. SD was appointed to the team in 2005 to coordinate the developmental work and to prepare a funding application for the main study.

Rangatiratanga

Researchers are not legislatively required to involve Māori researchers on research projects. However, from the inception of our project, a Māori researcher (BH) has been involved and in 2006 a second Māori researcher (EW) joined the team. We have shown how researchers are required to demonstrate research responsiveness to the Treaty and consultation with Māori. Consultation is not meant to be a presentation to Māori consultants of a fixed study design and plan – but is meant to allow incorporation of, and responses to, Māori thoughts and ideas about the study design, implementation and intended outcomes.

Consultation began when the research team held discussions with the NTRCC before developing the study idea and then made applications to the NTRCC for advice on the questionnaire development and pre-testing in early 2006, and later in 2006 for the pilot study. The NTRCC recommended that Māori be encouraged to participate in the research and commended the team on the work undertaken on 'cultural aspects of the proposition'. It was suggested that study results be made available to Māori health providers and sports bodies. The NTRCC also recommended that the team ensure information collected about ethnicity was based on the New Zealand Census ethnicity question.

In early 2006, BH and SD travelled to two of the study regions (Gisborne and Manukau City) to consult with *pakeke* (Māori advisors) about issues of importance for Māori regarding study design, research questions and desired outputs. In mid-2006–late 2007, with EW, meetings were held with *pakeke* in two more regions (Otago and Southland). Meetings were arranged pragmatically, through contacts with networks already established through this and other research projects, and within *iwi*.

Ōritetanga

Within Article III is the concept of equality/*ōritetanga*, and the requirement for researchers to demonstrate how their research is of relevance and benefit to Māori

health outcomes. During consultation with Māori *pakeke*, the researchers discussed the developing idea for a study examining barriers to, and facilitators of, good outcomes following injury; and that the researchers desired the involvement of Māori participants. It was discussed that a major aspect of the study would be the recruitment of, possibly, several thousand injured New Zealanders and following them up over time using repeat telephone interviews (and analysing results quantitatively).

The importance of the study focus – injury outcomes – was reinforced by *pakeke*. They emphasised problems Māori experienced accessing the Accident Compensation Corporation (ACC; New Zealand's no-fault injury treatment, rehabilitation and compensation insurer) and health service providers, and presented these difficulties to the research team through discussion of case study examples. During consultation, the research team was asked to address such inequities by focusing on those who did not reach the ACC or health services.

Pakeke also made imperative the need to have an in-depth qualitative component running alongside the proposed quantitative component, which the research team whole-heartedly agreed with. *Pakeke* reported that statistical approaches alone sometimes failed to highlight the particular difficulties Māori can experience, or presented results in a light that reflected badly on Māori and did not suggest opportunities for improving outcomes for Māori. The idea of a qualitative component also seemed pertinent to other groups in New Zealand. Therefore, a two-pronged design was developed for the qualitative component with: (1) Māori living within the *takiwā* where EW was undertaking her postdoctoral research forming one study and (2) other (non-Māori) injured New Zealanders from all study regions forming another.

Pakeke also emphasised the importance of including the perspectives of *whānau* (immediate and/or extended family) in the study. Although support was strongest for the qualitative component, there was also support for the quantitative component if sufficient numbers of Māori were recruited and results were sufficiently powered to inform service providers and policy-makers. The research team also supported this and we have endeavoured to meet this objective.

Accordingly, we were advised to include regions where a high proportion of the injured were Māori. Although *pakeke* accepted the research team's proposed use of telephone interviews, they emphasised the need to also make face-to-face interviews available for Māori. It was also advised that participation would be enhanced if a *te reo* Māori questionnaire was available (arguably the translation into *te reo* Māori could also be discussed in relation to Article II as it relates to the notion of *rangatiratanga*). All of these recommendations were included in the Study's development and design.

Table 1 shows our efforts, within the context of the Treaty and research-related legislation, during the development of our study.

Discussion

Consultation with Māori had a direct and substantial influence on the design and implementation of the Study. The NTRCC, *pakeke* and advisors from government agencies all supported and encouraged Māori participation through a variety of avenues. We adopted recommended strategies where possible, such as: recruiting

Table 1. Summary of relationships between the Treaty, legislation, research requirements and our responses.

The Treaty of Waitangi	Health and disability legislation	Health and disability research requirements	Our responses within the Prospective Outcomes of Injury Study
Article I Māori cede sovereignty to the British Crown. *Kāwanatanga* (Governorship)	Māori and other New Zealanders are covered by the New Zealand Public Health and Disability Act 2000.		
Article II In return Māori are guaranteed full exclusive rights of ownership and use of lands, forests, fisheries and other possessions. *Rangatiratanga* (Chieftainship)	Act requires mechanisms for Māori involvement in decision-making and delivery of health services.	MoRST, which manages research (via the HRC & other purchasers), states that research in relation to Māori development is a partnership between Māori and the Crown. Researchers to consult with Māori.	• Māori researchers asked to identify a researcher interested in helping develop the study. • Māori researcher involved in the preparation of developmental grant application (funded 2004). • Discussions and applications to the NTRCC in 2004 and 2006. • Consulted with various stakeholders, including *pakeke*, in study regions to learn about issues of importance and design. • Translated questionnaire and Study Information Sheet into *te reo* Māori.
Article III Māori enjoy the same rights and privileges as British citizens. *Ōritetanga* (Equality)		MoRST calls for a focus on '... achieving equity & reducing disparities for Māori'. HRC requires researchers to demonstrate how their research is of relevance to Māori health outcomes.	• Pilot study including Māori. • Advised to include regions with a high proportion of Māori. • Inclusion and emphasis on qualitative component for Māori and their *whānau*. • Required sufficient numbers of Māori for quantitative results to be benefit to Māori. • To meet regularly with interviewers and where possible appoint Māori interviewers via Māori organisations for local support.

from five regions of New Zealand including regions with a high proportion of injured Māori; aiming to over-sample Māori to 20% of the total sample recruited (500 injured Māori from a total of 2500 injured New Zealanders) to ensure sufficient numbers of Māori participants so that risk and protective factors could be analysed independently for Māori; including a specific Māori qualitative component managed by a Māori researcher (EW, supported by BH and SD); having interviewers located in each region available to do face-to-face interviews with Māori (and other New Zealanders) should this be desired by participants; appointing interviewers who were fluent in *te reo* Māori; and translation of the structured questionnaire and Study Information Sheet into *te reo* Māori by a postgraduate student who was supervised by expert *kaumātua* (elders) and CH. Parts of the questionnaire required independent forwards and backwards translators and lay testers from different *iwi* were involved.

Some recommendations received during consultation were not adopted by the research team. For example, *pakeke* desired the impact on and for *whānau* be incorporated within the study. Unfortunately, the study of thousands of injured New Zealanders was already expensive; to have incorporated interviews with all 500 injured Māori *whānau* as well would have been prohibitively so. It would have required extensive travel (for the researchers and *whānau*) around New Zealand and a great deal of coordination to ensure interviewers, the injured person and their *whānau* were gathered together. However, in an effort to respond to this recommendation, the structured questionnaires were developed to include questions about the injury and *whānau*. Furthermore, in the Māori qualitative component, *whānau* were encouraged to take part in the interviews, and the impacts of the injury on *whānau* were explicitly explored.

Pakeke also wanted the research team to include those Māori who did not access ACC and health services. Recruiting people not accessing the system, while important, was beyond both the practical and financial scope of the Study. However, questions were included in the interviews which specifically explored service barriers people experienced and whether people felt they had been treated unfairly by ACC and other health services because of their ethnicity.

Pakeke also recommended that regional interviewers be appointed and managed through local Māori organisations for support. Unfortunately, the temporal constraints and complexities of establishing Memorandum of Understandings with several different organisations, and ensuring interviewers were appointed with the skills, experience and consistency required to manage the structured, predominantly telephone, interviews necessitated interviewers being appointed, managed and trained via the host institution. However, advice about the need for regular support was able to be met and interviewers in regions remote to the host organisation are supported by regular email, telephone, teleconferencing and in-person meetings.

As a consequence of the involvement of Māori researchers from the project's inception and consultation with the NTRCC and *pakeke*, the Study has evolved into a study using a pragmatic mixed-method design. The three-year study, funded by the HRC and the ACC in mid-2007, aims to use (quantitative) epidemiological, economic and statistical methods and analyses to identify predictors of disability following injury in a sample of 2500 injured New Zealanders, 500 of whom are Māori (Derrett *et al.* 2009). Additionally, the two qualitative studies aim to shed light on the still largely invisible 'lived experiences' of Māori and other New

Zealanders. The intention, from the genesis of the qualitative project, was that 'Māori and non-Māori strands of the qualitative component will be analysed separately to ensure the Māori results have primary importance to, and for, Māori' (see 2006 funding application cited Derrett *et al*. 2009, p. e10).

Analysis of Māori qualitative data will be determined by the team and be led by the Māori researchers (EW and BH). This philosophy of Māori-led decision-making also extends to analysis of the Māori data from the quantitative study.

During the assessment for funding process, feedback from referees was mixed in relation to our efforts to address the principles of the Treaty. Comments included: 'The qualitative part of the study is well designed, and particular care has been taken to use a kaupapa Māori approach for the Māori part of the study' and '[it] is also very appropriately concerned with outcomes for Māori and has specifically designed processes to explore Māori experiences, and to inform Māori communities of the findings. The qualitative arm is likely to result in new and important information that may contribute to improved service delivery for Māori'. Another reviewer stated that it was imperative the research recruited sufficient numbers of Māori, but was pessimistic about the team's ability to follow-up Māori given the mobile nature of the Māori population. This reviewer supported the qualitative component of the study being led by Māori, but wanted more Māori researchers on the team familiar with quantitative methods and '*kaupapa* Māori epidemiology' (Simmonds *et al.* 2008). They levelled criticism at the relatively small amount of time budgeted for the Māori team members (BH and EW) and advised Māori-led analysis of Māori quantitative data. In response to these criticisms, we have been careful to collect information for alternative contact people should the participant move during the study follow-up period; EW has undertaken courses in quantitative methods and *kaupapa* Māori epidemiology, and will lead the quantitative analysis and interpretation of the Māori data-set with support from BH and the wider research team. In reality, we are all constrained by other work commitments and requirements.

Undeniably, and despite our best efforts, this national study is not a perfect model for addressing the principles of the Treaty in a health research environment. For example, additional Māori health models or questions could have been incorporated into our questionnaires, the consultation process could have been more extensive and the Māori qualitative component could have been extended beyond Otago and Southland.

The development of the present research's 'responsiveness to Māori' described in this paper may seem relatively unproblematic. Yet to many researchers outside New Zealand what has been achieved is perhaps incomprehensible regarding responsiveness to indigenous rights within the context of their own research environment. Increasingly in New Zealand, Māori-led projects are running in parallel to general population projects or are nested within these larger projects (such as, Cram *et al.* 2004, Adolescent Health Research Group 2008). However, this is not yet common practice in the broader New Zealand research context. Indeed, from the past experience of Māori researchers involved in the Study, resistance to incorporating a bicultural epistemology cognisant of *rangatiratanga* remains within the research community.

Anecdotally, the legislation and policies described above have instigated, among some New Zealand researchers, a 'tick-box' mentality without Māori having real

influence on, or buy-in to, the research. This dichotomy reflects a broader division within New Zealand society where the majority conceive biculturalism as tokenistic, envisaging Māori as mere informants. *Bona fide* biculturalism and consultation, on the other hand, involves Māori as influential decision-makers at all levels of the research process. Perhaps such resistance is underpinned by other researchers perceiving that recognition of an indigenous population is inherently inequitable. Research epistemologies providing 'affirmative action' become popularly labelled as 'reverse discrimination' or 'preferential treatment'. However, this position is blind to the historical injustices, poverty and suffering experienced by most colonised indigenous populations. Conversely, those with knowledge of Eurocentrism's history and the political, cultural and institutional imbalances of power acknowledge that recognition of the collective rights of an indigenous population is fundamental.

Recognition of Māori collective rights in any research project will, at times, face insurmountable barriers. Even researchers supportive of the collective rights of Māori face a research environment often at odds with dominant discourses concerning the rights of the individual. This burden falls particularly on Māori researchers who need to meet both the scientific expectations of research and to convey to multi-disciplinary, non-Māori team members the importance of, and processes for, gaining genuinely beneficial outcomes for Māori.

The Study endeavours to move beyond a 'tick-box' approach. Crucially, the concepts of *rangatiratanga* and *ōritetanga* were acknowledged in the development of this project. A team of Māori and non-Māori researchers was assembled, cognisant of authentic bicultural research and sharing decision-making processes equally, whilst incorporating within the research process an epistemology that recognises and values Māori perspectives.

Conclusion

We have examined the direct influence of the Treaty of Waitangi on the state of research policy in New Zealand, particularly the inclusion of the concepts of *rangatiratanga* and *ōritetanga*. As outlined below, these concepts are crucial to how we, as researchers, have come to self-assess our responsiveness to Māori and the principles of the Treaty during the development of our study.

Tensions between our efforts to genuinely respond to the Treaty by involvement, consultation and ultimately the design of a study capable of providing results of relevance to Māori health and disability outcomes are necessarily moderated by a number of factors including money and time. For example, our ability to travel to consult as widely as the ideal demands was limited and many of the research team are also involved in other research projects. Despite these constraints, we have developed good relationships with those involved. As the Study progresses, it now behoves us to ensure these relationships are sustained and that Māori consulted with continue to have input into the study, for example, receiving project updates and helping with the interpretation of results.

Ultimately, the 'proof will be in the pudding'. Will our study be able to provide results of significance and relevance to Māori in accordance with the Treaty? Will our study produce results capable of informing policy and reducing health and disability inequities? The study has almost finished recruitment. At the time of writing we can say that much rich information has been provided by Māori taking

part in the qualitative study so far, and that we have been successful in recruiting more than 500 Māori participants to the quantitative component; assessment of successful follow-up will need to await the passing of time.

The Treaty, as the foundation for our bicultural society, has been important in underpinning the need for acceptable, accountable and relevant research for Māori (via Article II's concept of *rangatiratanga*) and addressing health inequalities (via Article III's *ōritetanga*). We are also fortunate as a research team to be located at a University with clear established processes for consulting with Māori, in the first instance with Ngāi Tahu, the local *iwi*. As a consequence of the advice and insights shared during consultation with Māori, the research team believes that this Study, albeit imperfect, has been greatly enhanced for all study participants and the research team as a whole, not just Māori. While other colonised societies do not necessarily have such treaties, valuing and engaging with indigenous communities' epistemologies and values ought to offer the same opportunities for project and research team enrichment.

Acknowledgements

The authors gratefully acknowledge the HRC of New Zealand and the ACC for funding the Prospective Outcomes of Injury Study. Views and/or conclusions in this article are those of the authors and may not reflect the position of ACC. Dr Wyeth is also supported by a HRC of New Zealand Eru Pōmare Postdoctoral Fellowship. The authors would like to thank all those who have provided advice to date during the development and initial stages of this project. Drs Joanne Baxter and Dorothy Begg are also thanked for their helpful comments and suggestions on earlier versions of this article.

Notes

1. At the time of writing, the Study is in its recruitment phase.
2. Over 500 tribal representatives in approximately 40 different locations throughout the country over a seven-month period eventually signed the Treaty of Waitangi.
3. The overall purpose of the Health Research Council, as stated in the Health Research Council Act 1990, is to '... improve human health by promoting and funding research'.

References

Adolescent Health Research Group, 2008. *Youth'07: the health and wellbeing of secondary school students in New Zealand.* Auckland: The University of Auckland, Technical Report.

Bismarck, M., 2006. Ethnic disparities in claims and compensation following medical injury. Paper presented at *Mauri Ora: Māori health symposium*, 7 April, Wellington, New Zealand.

Cram, F., *et al.*, 2004. A 'parallel process'? Beginning a constructive conversation about a Maori methodology. *Journal of Bioethical Inquiry*, 1, 14–19.

Derrett, S., *et al.*, 2009. Prospective outcomes of injury study. *Injury Prevention*, 15, e3.

Goldberg, D.T., 1993. *Racist culture: philosophy and the politics of meaning*. Oxford: Blackwell.

Harris, A., 2004. *Hīkoi: forty years of Māori protest*. Wellington: Huia.

Health Research Council of New Zealand, 2008. *Guidelines for researchers on health research involving Māori.* Auckland: Health Research Council of New Zealand.

King, M., 2007. *The Penguin history of New Zealand illustrated*. Auckland: Penguin Group (NZ).

Koea, J.B., 2008. Indigenous trauma: a New Zealand perspective. *Injury*, 39 (Suppl. 5), S11–S18.

Lange, R., 1999. *May the people live: a history of Maori health development 1900–1920*. Auckland: Auckland University Press.

Langley, J. and Broughton, J., 1998. *Nga Tatauranga: injury to Māori*. Dunedin: Injury Prevention Research Unit and the Ngāi Tahu Māori Health Research Unit.
Ministry of Health, 2001. *Priorities for Māori and Pacific health: evidence from epidemiology.* Wellington: Ministry of Health.
Ministry of Health, 2006. *Operational standard for ethics committees: updated edition.* Wellington: Ministry of Health.
Ministry of Research, Science and Technology, 2004. *A 'snapshot' of vote research, science & technology investment in 'Māori research'.* Wellington: Ministry of Research Science and Technology.
Nash, K., 2001. The 'cultural turn' in social theory: towards a theory of cultural politics. *Sociology*, 35, 77–92.
National Ethics Advisory Committee, 2006. *Ethical guidelines for observational studies: observational research, audits and related activities.* Wellington: Ministry of Health.
O'Regan, T., 2001. Old myths and new politics – some contemporary uses of traditional history. *In*: J. Binney, ed. *The shaping of history.* Wellington: Bridget Williams Books, 15–37.
O'Regan, T., 2008. Impact on Māori – a Ngāi Tahu perspective. *In*: J. Ruru, ed. *'In Good Faith' symposium proceedings marking the 20th anniversary of the lands case.* Wellington: New Zealand Law Foundation, 41–50.
Orange, C., 2001. *The Treaty of Waitangi*. Reprint ed. Wellington: Bridget Williams Books.
Popkin, H., ed., 1999. *The Pimlico history of western philosophy.* London: Pimlico Random House.
Rata, E., 2005. Rethinking biculturalism. *Anthropological Theory*, 5, 267–284.
Reid, P. and Robson, B., 2007. Understanding health inequities. *In*: B. Robson and R. Harris, eds. *Hauora: Maori standards of health IV. A study of the years 2000–2005*. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare, 3–10.
Ruru, J., 2008. Introduction. *In*: J. Ruru, ed. *'In Good Faith' symposium proceedings marking the 20th anniversary of the lands case.* Wellington: New Zealand Law Foundation, 1–9.
Simmonds, S., *et al.*, 2008. Kaupapa Māori epidemiology. *Australasian Epidemiologist*, 15, 3– 6.
Smith, L.T., 1999. Research adventures on indigenous lands. *In*: *Decolonizing methodologies – research and indigenous peoples.* 6th impression. Dunedin: University of Otago Press, 78–94.
Statistics New Zealand, 2007. *QuickStats about Māori.* Revised ed. Wellington: Statistics New Zealand.
Statistics New Zealand, 2008. *New Zealand period life tables: 2005–2007.* Wellington: Statistics New Zealand.
Tipene-Matua, B. and Dawson, J., 2003. The Treaty of Waitangi and research. *In*: J. Dawson and N. Peart, eds. *The law of research – a guide.* Dunedin: University of Otago Press, 61–79.
University of Otago, 2003. *Research consultation with Māori policy* [online]. Available from: http://www.otago.ac.nz/research/maoriconsultation/policy.html [Accessed 11 August 2008].
Van Beeck, E.F., *et al.*, 2007. Guidelines for the conduction of follow-up studies measuring injury-related disability. *Journal of Trauma*, 62, 534–550.
Ward, A., 1973. *A show of justice.* Auckland: Auckland University Press.
World Health Organization, 2008. *The global burden of disease: 2004 update.* Geneva: World Health Organization.