IN THE WAITANGI TRIBUNAL

Wai 2180, Wai 1705, Wai 647, Wai 588, Wai 385, Wai 581, Wai 1888

IN THE MATTER OF	the Treaty of Waitangi Act 1975 and the Taihape: Rangitikei ki Rangipo Inquiry (Wai 2180)
IN THE MATTER OF	a claim by Isaac Hunter, Utiku Potaka, Maria Taiuru, Hari Benevides, Moira Raukawa-Haskell, Te Rangianganoa Hawira, Kelly Thompson, Barbara Ball and Richard Steedman on behalf of themselves, the Iwi organisations who have authorised them to make this claim and the Mōkai Pātea Waitangi Claims Trust (**Wai 1705**)
AND	a claim by Maria Taiuru and others for and on behalf of Wai 647 Claimants (**Wai 647**)
AND	a claim by Isaac Hunter and Maria Taiuru and others for and on behalf of the Wai 588 Claimants (**Wai 588**)
AND	a claim by Neville Franze Te Ngahoa Lomax and others for and behalf of the Potaka Whanau Trust and Nga Hapu o Ngati Hauiti (**Wai 385**)
AND	a claim by Neville Franze Te Ngahoa Lomax and others for and behalf of Te Runanga o Ngati Hauiti (**Wai 581**)
AND	a claim by Iria Te Rangi Halbert and others for and behalf of the Wai 1888 Claimants (**Wai 1888**)

Statement of Evidence of Heather Hyland Gifford
12 February 2018

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Statement of Evidence of Heather Hyland Gifford

Ko Tākitimu te waka
Ko Ngāti Hauiti te iwi
Ko Ruahine te pae maunga
Ko Rangitīkei te awa
Ko Ngāti Haukaha te hapū
Ko Rātā te marae

Ko Mohi Pirere toku Tipuna
Ko Tawhara Pirere te kuia
Ko Barney Tamatea Hyland te matua
Ko Heather Gifford tōku ingoa
Tēnā koutou katoa

1. My background and training is in nursing with a Masters in Public Health and Doctorate in Māori Studies. Over the last twenty years I have worked as a voluntary manager for Ngāti Hauiti health and social services delivery arm.

2. I have represented the iwi on several Māori health governance boards in the region, and in 2004 I established Ngati Hauiti's health research centre: Whakauae Research for Maori Health and Development. We have a well-established New Zealand wide presence in Māori health research undertaking a range of local, national and international public health research programmes. My research career has been focused on tobacco control research and prevention through public policy lens.

3. The purpose of my kōrero today is to discuss the impact of colonisation on the health and wellbeing of Ngāti Hauiti members with particular reference to tobacco smoking as a tool of colonisation.

4. In 2000 I started my doctorate with Te Pumanawa Hauora, Massey University. The ultimate outcome from this research project was to reduce the uptake of tobacco smoking in the tamariki/rangatahi population of Ngāti Hauiti. Phase One, the doctoral research,

developed multiple sets of principles and strategies (the conceptual framework) to guide the implementation of a tobacco intervention strategy for Ngāti Hauiti. Phases Two and Three, the intervention research used these principles and strategies in the ongoing tobacco control research with Ngāti Hauiti, and in particular, in the development, design, pilot testing and final evaluation of the tobacco control intervention programme.

5. The qualitative paradigm sought to establish context and meaning surrounding the uptake of tobacco smoking. The research was conducted with a group of Ngāti Hauiti tamariki/rangatahi. While the primary focus was youth, these youth were viewed in the context of their whānau, hapū and iwi; and the historical, social, economic and cultural context of smoking was analysed. The research built on a previous study of alcohol and drug use by Ngāti Hauiti Rangatahi (Tauwhare, 1999) that identified a youth prevalence rate of smoking in this population above the Māori national average.

6. I **attach** a copy of my doctoral thesis "*Reducing the uptake of tobacco in Ngāti Hauiti Rangatahi"*, completed in 2003 at Massey University.

Background for the smoking epidemic

7. The following section highlights smoking as a major health issue and briefly discusses the introduction and uptake of tobacco for Māori. The section covers some of the major contributing factors for current Māori smoking rates.

8. Tobacco is the leading cause of preventable death in New Zealand and is known to cause various types of cancers, heart disease and respiratory illnesses such as emphysema. As well as harm to smokers, tobacco products cause harm to non-smokers by exposure to tobacco smoke.

9. Smoking is a major issue for Māori in terms of health, equity, economic status and cultural identity as smoking rates, for both adults and youth, are about double the New Zealand European rate. Latest data shows 35% of Māori adults are current smokers, compared with almost 16% for non-Māori. Adults living in the most socio-economically deprived areas were more than 3 times as likely to be current smokers as people living in the least deprived areas, after adjusting for age, sex and ethnic differences. (https://www.health.govt.nz/publication/annual-update-key-results-2016-17-new-zealand-health-survey)

10. Before European contact there was no smoking of tobacco or any other substances by Māori (Broughton, 1996). Tobacco was introduced to New Zealand by early Pākehā explorers and traders and was used as a currency and article of trade. Its use quickly became popular among Māori as evidenced both by data on smoking rates collected for the New Zealand Official Year Book 1883, and by many photographs and portraits of the day that depicted Māori and pipe smoking as virtually synonymous (Reid & Pouwhare, 1991). The New Zealand Government acknowledged the heavy involvement of Māori with tobacco as early as 1894, and by 1900 Māori public health leaders such as Maui Pomare recognized the adverse effect smoking was having on Māori health (Broughton, 1996).

11. During the first half of the 1900s, Māori, like their Pākehā counterparts, changed from pipe smoking to cigarettes. Cigarettes were made commercially viable by the invention of the cigarette rolling machine and the introduction of safety matches, and consumption was greatly facilitated by free distribution of cigarettes to soldiers during both World Wars. The change from pipe smoking to cigarette smoking, with its associated increase in uptake of nicotine, accelerated Māori death rates from tobacco use.

12. Around 80% of all men born before 1926 went through a regular smoking phase, and a very high proportion of these men would have

had service experience (Easton, 1995). The smoking prevalence among Māori men was consistently 75–80% for the whole period (1896–1951). During the same period there was an increase in women's smoking in the Western world, facilitated by targeted advertising, women's increasing independence and increasing social acceptability of women smoking (Reid & Pouwhare, 1991). For the generation of women born in the 1920s, the prevalence was about 50%, a level that continued at least to those born in the early 1950s (Easton, 1995). By the 1950s, early reports emerged linking tobacco use with illness, especially lung cancer.

13. However smoking prevalence rates for Māori over the greater part of the 1900s remained high for both Māori men and women (Reid & Pouwhare, 1991), and a decline in the percentage of Māori smoking was not evidenced till after 1980. In 1981, tobacco consumption per Māori adult was higher than in any other Western industrialised country, and 56% of the Māori population smoked regularly (Laugesan & Clements, 1998). As discussed previously smoking rates for Māori are still over twice that of non-Maori in 2017 with significant regional variation evident in places such as Whanganui and the Rangitikei (Whanganui Tobacco Control Group 2017 states high rates of smoking in Māori in the Whanganui Rangitikei region).

14. One reason given for this disparity is the marginalized position of Māori with respect to mainstream New Zealand society (Te Puni Kōkiri, 1993).

Contribution of colonisation to smoking

15. Colonisation resulted in the economic and cultural downfall of Ngāti Hauiti. Land loss and subsequent impact on economic wellbeing, disruption to social support networks, high levels of stress and loss of tikanga that guided traditional healthy behaviors, all contributed to high levels of smoking.

16. I will now briefly outline how colonisation has impacted on Ngāti Hauiti health, and in particular the contribution of colonisation to high smoking rates.

16.1 The introduction of tobacco on first contact. Tobacco and nicotine were unknown in traditional pre-contact Māori society.

16.2 The increased access to tobacco facilitated through western methods of production and active distribution methods (particularly evident through the exposure to smoking for young Ngāti Hauiti men during World War 1 and World War 2). A further breakdown in this iwi structure occurred on the return of our servicemen. Many found it difficult to readjust to a civilian lifestyle and to settle back into their pre-war occupations in close proximity to their whānau. Their battle experiences were not easy to forget and the loss of so many of their friends and comrades during these battles had affected them dramatically. Alcohol and addiction became a symptom of this disruption. It was also difficult for some to adjust to the re-establishment of relationships within their whānau and hapū.

16.3 Early advice from Māori doctors was largely ignored. (Broughton 1996).

16.4 The introduction and quick uptake of Christianity in our rohe, spread by missionaries Colenso and Taylor, challenged much of the traditional health teachings and tikanga of the Ngāti Hauiti elders.

16.5 The loss of tribal land resulted in significant economic disparity. The individualisation of title facilitated acquisition of land for settlers. Between 1880 and 1910 significant tracts of tribal estate were alienated. There is

very strong evidence of the link between poverty and smoking.

16.6 Many owners were absent from the land. Money was also needed to support the new lifestyle introduced by the Pākehā. By and large the only lands retained within Ngāti Hauiti were those on which tribal members were living. The predominant families remaining in the rohe were those farming the land, and included the Potaka, Hunia, Winiata, Te Rango, Pirere, and Merehira Te Taipu whānau. However, as the old rangatira died the strong kinship ties they had maintained began to crumble and more and more families began to sell their land and take up the manual labouring work the rural economy provided. Disintegration of iwi and whānau networks resulted in stress and isolation. There is very strong evidence linking stress with continued smoking and alcohol use.

16.7 Our people realised the benefits of prosperity and wealth gained from modern technology, which usually meant the adoption of Western values and ways of living. The resulting effect longer term, however, was a loss of cultural identity and the eventual urbanisation of the iwi. The loss of cultural identity meant that previously employed tikanga, that resulted in healthy lifestyles prior to colonisation, was increasingly unavailable to Ngāti Hauiti members. (Parata & Gifford 2017; Durie 1998)

16.8 Many of our Ngāti Hauiti moved out of the district and into the city to take advantage of opportunities offered by larger centres. A robust post-war economy provided many opportunities for employment. The availability of housing finance and restriction on building on multiple-owned Māori land encouraged more Māori whānau to build and stay in the cities rather than return to their tupuna whenua. By the

early 1960s virtually all the Ngāti Hauiti kaumātua born in the 19th century had died, and the communities around the marae were almost deserted. Little interest was taken in marae and iwi affairs, and with the deaths of so many kuia and koroua it was not long before marae life became spasmodic and, in the case of the Rata Marae, the marae committee disbanded and the wharepuni and wharekai were left to decay. Very few whānau were now living close to the marae, and speakers of Te Reo Māori within the iwi were almost non-existent. The earlier encouragement for children of Ngāti Hauiti to excel in the pākehā education system had advanced at the expense of Te Reo Rangatira. Government policy over many years had led Ngāti Hauiti tūpuna to believe that there was no future for the Māori language and tikanga Māori and that children would experience difficulties in their education if they did not concentrate on learning the now dominant English language.

Summary

17. In summary, tobacco continues to take a devastating toll on Ngāti Hauiti members through illness and death of our whanau.

18. In my opinion smoking is inextricably linked with colonisation and current rates of Māori smoking need to be urgently addressed by the Crown.

19. Continued disparities in smoking rates between Māori and non-Māori are evidence of the failure of the Crown to adequately address the ongoing health needs of Māori. Given the stark disparities in smoking in the Whanganui DHB region (which includes Ngāti Hauiti) it is particularly important issue for us within Ngāti Hauiti.

20. It is not unreasonable under a Treaty framework to expect health outcomes similar to non-Māori (this is currently not the case). Māori political leaders, including one of our close whanaunga Dame

Tariana Turia, have committed this nation to a smokefree goal by 2025 with ALL smoking to under 5% across the whole population. To achieve this Ngāti Hauiti will need sufficient resources to address this problem, and to do so within the paradign of Ngāti Hauiti tikanga. Any intervention to reduce smoking for our members will need to consider the importance of tackling the range of determinants, including socio-economic disparity and ethnic differences as well as the impacts of colonisation and the resulting marginalized position of Hauiti and other Māori within contemporary Aotearoa.

21. My thesis on the uptake of tobacco among Ngāti Hauiti rangatahi concluded that a comprehensive Māori tobacco intervention strategy, based on traditional vlaues, using current iwi development principles and incorporating contemporary evidence would impact in significant ways on the attitude to smoking in Ngāti Hauiti rangatahi and whanau. I argued for the adoption of whānau-centred policies aimed at prevention. After graduating with a PhD I was awarded a Post Doctoral Scholarship from the Health Research Council of NZ. With this funding we undertook a three year intervention using Hauititanga to influence uptake of tobacco in Hauiti whānau. The results were mixed with some success in strengthening identity and increase in smokefree messages being adopted at a whānau level. I have spent the last twelve years continuing to work in Māori tobacco control and have published extensively in the area.

22. I dedicate this korero to my whangai parents Josephine Mapeka Hyland and George Gifford both of whom died prematurely of lung cancer associated with a lifetime of smoking.

Heather Gifford
12 February 2018

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